MACC Care (Austin Rose) Limited

Austin Rose Care Home

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on the 11 and 12 September 2018. It was the first inspection of this home since it was registered with the Care Quality Commission.
Austin Rose 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.

Austin Rose can accommodate 80 people in one adapted building. At the time of our inspection there were 71 people living there. Austin Rose is a purpose-built nursing home and has a number of dining rooms, lounges outside spaces and other facilities for people to use such as a small cinema.

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

The service was not consistently safe and had not kept people free from the risk of potential harm due to poor staff knowledge about risks and a lack of risk assessments concerning how to support people to eat safely.. Other areas of the service were safe such as the processes to report safeguarding and the administration of peoples' medication. Austin Rose was clean and people were protected from the risks of cross infections.

The service was not consistently effective as staff had received very little supervision and had not received timely training in all areas. While the home was clean and spacious it did not meet the needs of people living with dementia well. People had food to eat that they enjoyed but were not supported to eat their meals in a way that encouraged them to enjoy the mealtime as a social activity. There were policies and systems in place to support appropriate practice in relation to the Mental Capacity Act. However, people were not consistently supported to have maximum choice and control of their lives and staff did not consistently support them in the least restrictive way possible. The provider was following the legal requirements of the MCA and had submitted DoLS applications as necessary. Where these had been authorised, the provider was compliant with the conditions of the authorisation. However, the provider had not properly trained or prepared staff to understand the specific requirements of DoLS. People had good access to healthcare professionals.

People were not consistently supported in a caring manner as some aspects of how people were supported to move was not dignified. We saw that independence was promoted for people who lived at Austin Rose for short periods of time but there was no focus on this part of peoples' life if they lived at the home on a long-term basis. It was not clear how people were meaningfully involved in their care. People and relatives told us that staff were kind and caring and we saw examples of compassionate care.

The service did not always respond to people's needs well. People did not have sufficient access to activities or meaningful occupations. People and relatives had access to a complaints process but not all complaints had been recorded and dealt with by this process, so some learning may have been missed. Peoples' needs had been assessed but this process did not always include the person or their relatives in a meaningful manner. People had basic end of life plans if needed.

Austin Rose was not always well led. There were concerns about the poor quality of the auditing process which meant that issues were missed and improvements not made. We also found that people were not as involved in the running of the home or their care as they could be. Everyone we spoke with said they thought the management of the home was good and the registered manager understood their responsibilities under the law.

We found two breaches of regulation during this inspection. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

People did not all have risk assessments in place to keep them safe.
People were supported by enough staff.
People received their medicines safely.
People were kept safe from the risks associated with infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported by staff who were supervised or well trained.
People had good food to eat but were not supported to enjoy the mealtime.
People were not supported by staff who understood the law in relation to Deprivation of Liberties.
People had good access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported in a dignified manner.
People were not always supported to maintain their independence.
People told us and we saw that staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have sufficient access to activities or meaningful occupations.
People had access to a complaints process but not all complaints had been addressed through this process.
Peoples needs had been assessed but this process did not always include the person.
People had basic end of life plans if needed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People did not receive a service that had been audited well or effectively.
People were not routinely involved in the home or their care planning.
The service did not effectively learn from concerns or gain the views of people or their relatives to improve the service.
There was a clear leadership structure in place which was well regarded.

Austin Rose 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 checked 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 unannounced comprehensive inspection took place on 11 and 12 September 2018. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On the second day of the inspection, two inspectors visited Austin Rose Care Home.

As part of the inspection process we looked at information we already held about the provider. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

As part of planning the inspection we checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We also looked at any information that had been sent to us by the commissioners of the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also examined the information we hold in relation to the provider and the service. We used this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit, we met and spoke with 8 people who lived at the home and 10 relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time. We spoke with 4 visiting care professionals to get their views. In addition, we spoke at length with the registered manager, the regional compliance officer, the deputy manager, 9 care staff, 2 nurses and two

senior care staff. We reviewed various records of people and other records kept by the registered manager in relation to running the service.

After the inspection, the provider sent us the information we had requested during the inspection.

Requires Improvement

Is the service safe?

Our findings

This was the first inspection of this service and we have rated it as Requires Improvement. We have also found that the provider was in breach of Regulation 12.

Risks to people were not consistently managed well, and people were not always kept safe. We saw people had care records that varied in how up to date they were and how accurate they were. These care records did not always include all the risk assessments needed to keep people safe. For example, one person was at risk of choking and this information had been given to Austin Rose by the hospital they had recently left. We found that the person did not have a risk assessment relating to this. During our inspection we saw that staff did not support the person to eat in a safe manner and as a result the person experienced a serious choking incident that required emergency first aid to be given, which was successful.

In another example we saw that one person needed to have their fluids carefully monitored and managed to keep them safe and well. We saw they had a risk assessment in place that specified the support they needed. However, we also saw that this risk assessment was not being followed by staff and the person was having more fluid than was safe for them or not having the fluid amount monitored so staff did not know how much they had drunk in a day. Due to the serious nature of the person's medical condition this meant that they were not being supported in a safe manner.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff knew what constituted abuse and what to do if they suspected someone was being abused. They knew how to report their concerns to the registered manager and to external agencies such as the Care Quality Commission or the Local Authority. Staff we spoke with could confidently describe the different signs and symptoms that a person might present which would indicate they were being abused and confirmed that they had received training in safeguarding to support their understanding. The registered manager had a good understanding of their responsibilities in maintaining the safety of people from harm. They had notified us about concerns they had in relation to people's safety which included any incidents of potential abuse or serious injury to people.

We saw that plans were in place to manage emergency situations. In the event of a fire emergency evacuation plans were in place for each person which detailed whether people needed equipment to mobilise. Staff we spoke with were consistent in their response to what action to take in the event of a fire or an emergency situation.

People and relatives felt there were sufficient numbers of staff to respond to their or their family member's care and support needs. One person said, "I definitely feel safe here, there is always someone around if I need help or anything." The majority of relatives we spoke with said that there were enough staff available to meet people's needs. One relative said, "I believe that my relative is safe as the staff are good," We saw that staff were consistently in the vicinity of communal areas and responded to people's requests for support.

We looked at the recruitment process in place to check the suitability of the staff to work with people who lived at the home. We looked at four staff recruitment records and saw the provider had completed appropriate recruitment checks prior to staff starting work at the service. We saw reference checks, identity verification and Disclosure and Barring Service (DBS) checks had been completed. DBS checks helps providers reduce the risk of employing unsuitable staff. We also saw the provider completed checks of nursing staff registration to ensure this was current. This showed the provider had adequate systems in place to ensure staff were suitable to work within a care service.

People received their medicines on time and as prescribed by their GP. Relatives told us they were happy with the way their family members were supported with their medicines, one relative said, " [My relative] came here on palliative care, we have not had any problems with the home." We observed a nurse preparing and administrating people's medicines. We saw that they informed people about their medicines and asked if they required any pain killing medication. Medicines were administered in a safe and unrushed manner. We observed the nurse obtaining consent from people before giving them their prescribed medicines.

We looked at the medicine administration record (MAR) and the controlled drugs book for some people who lived at the home. We checked the balances for some people's medicines and they were accurate with the record of what medicines had been administered. We saw that staff were signing to indicate that prescribed creams had been applied. We saw that medicines were kept in a suitably safe location, and disposed of correctly if they were not used. We also found guidance was available for staff to refer to in relation to safely applying medicines via skin patches on a person's body. We found fridge and room temperatures were being recorded and medicines were stored within safe conditions. Where medicines were prescribed to be administered 'as required', there were instructions for staff which provided information about the person's symptoms and conditions which would mean that they should be administered. People received their medicines safely and when they needed them.

Senior staff carried out regular audits of Medicine Administration Records (MAR) to ensure that people received their medicines as prescribed. We saw a sample of these audits that confirmed this.

We found that people were protected from the spread of infections, and staff ensured that the home was clean and hygienic at all times. People looked well kempt and a relative told us, "[My relative] is clean and has clean clothes on every time I have been to see them." All areas of the home were clean and smelt fresh. We saw that cleaning schedules were in place with a list of cleaning duties to be completed. We saw that chemicals and cleaning materials were kept safely locked away and did not present a danger to people. There was good hand washing facilities in people's rooms, and communal areas with each room having an individual soap and paper towel dispenser. We observed that food hygiene standards were good and did not present any visible concerns. We saw and staff confirmed they used personal protective equipment such as gloves and aprons to prevent the risk of cross infection, and keep people safe. Staff had received training in infection control and told us they felt confident to implement it.

Staff told us they knew how to report any accidents and explained how they had done so in the past. We saw the registered manager recorded any incidents and accidents, and noted they had responded to any immediate concerns in each case. However, they did not routinely audit them to look for improvement or identify any trends.

Requires Improvement

Is the service effective?

Our findings

This was the first inspection of this service and in this key area we found that it requires improvement.

Staff we spoke with told us that they had not received regular supervision to reflect on their care practices and to enable them to care and support people effectively. One member of staff told us, "We haven't had supervision." We spoke with the registered manager who confirmed that supervisions had not taken place and could not provide us with evidence that clinical supervisions for qualified nurses had been conducted. We saw that the number of staff who had received supervision was significantly lower than the provider had planned with only twenty-one care staff having an individual meeting since the beginning of the calendar year to discuss their development and learning needs. Staff had also not been supported to have spot checks or observed practices to ensure they were performing to a good standard, and aid their learning. Nurse staff had begun to receive clinical supervisions but there was no evidence to suggest that their competencies had been reviewed as part of this process.

People were supported by staff who had access to training on a variety of core areas and some staff had commenced working at the home with NVQ qualifications in care. However many staff had not received updated training which meant that their skills and knowledge were not up to date. The majority of the training provided was delivered on-line with practical supplementary training provided for some topics such as safely moving and handling people or fire safety training. Staff had received some training but we saw that the practice of some staff was not skilled and people were supported to move using hoists without due regard for their comfort dignity or emotional well-being. These issues were raised with the registered manager.

People had been assessed in relation to the risk of inadequate nutrition and hydration and food and where appropriate, and we saw that fluid intake was monitored. However, whilst fluid intake was being monitored it was not done consistently well, and it was not clear from records what action had been taken when people had not received, or had exceeded their daily target for fluid consumption. We saw that people, when needed were weighed regularly and that referrals were made to the health professionals for advice and support.

During our observation of lunch time however we saw that people were not supported to enjoy their meals well. We saw people were seated where they could not see each other well. People were made to wait up to 20 minutes for their food while others ate. One person was seated 'side on' to the table and had to reach across themselves to eat. We noted that the person often dropped their food and was becoming distressed by this.One person was supported to eat their meal by a staff member who did not speak with them, or tell them what food they were eating. Two people were not given time to eat at their own pace and were given food before they had swallowed the previous mouthful. One person went on to choke. We saw that staff did not have the knowledge or skills to support people with their meals effectively.

People were supported to exercise choice about the meals they had and had drinks provided at regular intervals throughout the day. We saw that there were usually two choices made available at each mealtime

and were advised that if a person did not like what was being served another alternative would be provided. The home served a range of food that was freshly prepared and we saw that a range of fresh produce was used. People told us they liked the food, one person said, "I have no problem with the food or quality and quantity of food. I am happy with the choices of food there are." Relatives told us they were happy with the quality and quantity of the food. A very recent Environmental Health inspection gave Austin Rose the top rating of 5 stars. We observed a lunch time and saw that food was prepared in line with people's needs. For example, where it was specified in peoples' care plans that they needed to have a certain consistency of food or drink this was known about by staff, and peoples' food had been prepared correctly for them.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that the registered manager had sought and taken appropriate advice in relation to people in the home. The registered manager had made DoLS applications for people living in the home as they did not have the capacity to make some decisions for themselves. These applications had been sent to the appropriate local supervisory body. The registered manager kept a list of when the applications would expire so that they could be re applied for if needed.

None of the staff we spoke with however, knew about the requirements of DoLS and the Mental Capacity Act in relation to the people who lived at Austin Rose. Staff said they would restrict most people from leaving the building and did not have knowledge about where to go to find out who could legally be restricted in such a manner. Staff gave conflicting answers and were not clear who was subject to a DoLS. Staff told us they had received some training to support them in understanding their responsibilities, but we found this was not effective.

The premises had been built and decorated to support people to move easily from their own bedroom and around the communal areas of the home. There were large and plentiful communal spaces for people to use and meet with friends or relatives if they wished. There was a garden which people could use independently or with support from staff. There were other safe outdoor spaces for people to use such as protected balconies, plus an indoor cinema and gym area for people to use. The décor, furniture and fixtures & fixings were of a high standard but some areas of the home would benefit from provision of improved orientation and access to objects of interest that people living with dementia might find interesting for reminiscence. In the ground floor lounge there was a box with toys, focus mitts and DVDs of childhood days. There were no visual aids such as posters of bygone days for service users. The provider had not followed national guidance in relation to signage and decoration, such as signs on toilet doors, to facilitate people moving about the home who were living with dementia.

People and their relatives and professionals had been consulted about individual needs and the information obtained was used to inform care plans in the home. We saw that records contained assessments about a variety of aspects of each person's care and these were regularly reviewed to ensure

that people received appropriate support. The assessments of people's support and care needs varied in respect of detail and was not always as comprehensive as required. Information from involved healthcare professionals when available was used to inform specific nursing plans and staff liaised with professionals as necessary to raise issues or to determine how specific health issues were to be addressed when there were concerns.

We saw that staff participated and contributed to handovers between shifts which enabled staff to facilitate continuity and provide the best possible outcome for people. Staff we spoke with told us that communication was effective within the team. One member of staff said, "My colleagues are brilliant and we work together well."

We saw that people were supported to access a range of health care support which included, district nurses, GPs, dentist and opticians. One relative told us, "I feel that when I have talked to the nurses that they have listened – for example medication issues/health needs. If there are any issues with my relative then they get the GP in." During our inspection we spoke with a visiting health care professional who told us they felt that the delivery of health care at Austin Rose was good. We saw that care plans contained dates and outcomes of health care visits.

Requires Improvement

Is the service caring?

Our findings

This was the first inspection of this service and in this key area we found that it requires improvement.

People were not supported to move about the home in a dignified manner. We saw examples of people's dignity being compromised when they were using the hoist. For example, one person had their legs uncovered to an unacceptable extent and were left in that manner during the whole hoist procedure. No staff attempted to pull their clothes down or cover their legs. Another person was left hanging in the hoist at an unnecessarily high level for an unnecessarily long amount of time without reassurance of any kind being given by staff. One member of staff told us, "People are scared when they are hoisted." Communication from the staff to ensure the comfort of people during these manoeuvres was not sufficient to reassure them. People were not consistently treated in a kind or dignified manner.

We did not see examples of people being supported to maintain their independence consistently across the home. We noted that one floor of the home supported people towards independence as they only stayed at the home for a limited amount of time after leaving hospital. However, people who lived in the home on a more permanent basis did not have independence as part of their care planning or activities. Members of staff who worked on these floors could not give us examples of how people's independence was promoted.

People and relatives, we spoke with did not tell us that they had been regularly involved in the reviews of care plans. We looked at the records and noted that the process for involving people and their relatives was unclear. We also noted that in a very recent visit from the Local Authority we saw that they had also noted concerns in relation to care plan reviews not being held with people and relatives' involvement. We spoke to the registered manager in relation to this and they were unable to provide us with assurances that people and their relatives were consistently involved in the planning of their care in a meaningful manner.

People told us that they considered that the service was caring. One person said that, "I am well looked after, everything I ask for has been provided, they are very good." A family member said, "My relative is getting good care here." Another relative told us, "I am so grateful to the team for the care they give, nothing is too much trouble for them, I cannot believe the capacity for caring that these staff show."

All the staff members that we spoke with talked about the people whom they supported in a positive, caring and respectful way. A staff member said, "The staff are all caring and sometimes give people more than their job." Another staff member said, "It's like a big family here, we are really welcoming here, everyone gets birthday cards and presents and has a party." All the staff we spoke with told us they would be happy for a relative or loved one of theirs to move into Austin Rose. During the inspection, we spent time in communal areas observing kind and friendly interactions between staff and people. People were supported by a regular team of staff who were familiar with their likes, dislikes and preferences.

People's care plans contained information about how staff members should support them to make choices about how their care was delivered. Plans included information about people's religious, cultural, communication and other personal needs and preferences, and information was provided on how these

should be supported by staff. The registered manager told us that, where possible, care staff were provided who could meet people's specific cultural and language needs. Care was provided by staff who were of the same gender and could speak the same language where this was required by the person, for example one relative told us that their wife always received care from a female carer as she wished.

At the time of our inspection no-one using the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager had details of advocacy services which could be contacted if people needed independent support to express their views or wishes about their lives. People's privacy was protected as we saw they received personal care in private and were given their medicines in a discreet manner. The registered manager and staff were aware of the need to maintain confidentiality in relation to people's personal information. We saw personal files were stored securely in the office and computer documents were password protected when necessary.

Requires Improvement

Is the service responsive?

Our findings

This was the first inspection of this service and in this key area we found that it requires improvement.

Activities were provided in the home, but we found that the range and amount of activities was limited. We saw that many people were in their bedrooms for long periods of time and it was not clear if this was their choice. We noted that people who spent time in their bedrooms were not actively involved in activities. Staff told us people remained in their bedrooms as the home did not have enough specialist chairs to move people about safely. When we raised this with the registered manager it was unclear if all the people in their bedrooms needed specialist equipment, or if they could be assisted to sit out in a standard armchair. The registered manager said they would review this concern. We found that people were not given the opportunity to take part in meaningful activities and the service had not been responsive to this need.

Some activities such as painting nails as a whole morning activity meant that only a very small number of people had activities of interest or linked to what they had identified they liked to do. Other activities involved more people and were delivered in different parts of the home. The provider had an activities coordinator and had recently recruited another member of staff to extend the service's current activities programme.

People and relatives we spoke with told us that they knew how to make a complaint. Staff we spoke with told us that complaints raised directly with them would be resolved at a low level if possible and therefore not recorded in the complaints log, but that they would be noted in either the handover book or in the person's daily notes. This process did not give the registered manager an overview of concerns or the ability to improve the service as a result of them.

We saw that the home had a system of recording complaints and noted those that were recorded had been investigated in a timely and appropriate manner. However, we found through talking with a relative that they had raised a complaint three times and were in fact in contact with the provider to seek a resolution. We checked the complaints log again it was clear that no record of receiving this complaint had been made. We raised this with the registered manager who assured us it would be recorded and acted upon.

We saw that systems were in place to ensure that care plans are regularly evaluated and reviewed however the involvement of people in such reviews varied. For example, one care plan did not identify the person's preferred name. However, another care plan clearly described a person's religious preferences and their relative confirmed that their care was delivered in line with these wishes. Care plans were often focussed on each person's physical care and support needs rather than their emotional well-being and lacked detail about how some people liked to keep busy. The registered manager advised that staff would be focussing on a 'resident of the day' on each floor of the home. This focus was to be comprehensive with all aspects of support that a person received or needed being reviewed.

The Accessible Information Standard of 2017 defines a way of identifying, recording, and sharing people's communication needs. The standard aims to improve the health, care and wellbeing people receive by

making sure they are communicated with in a way that suits them. This helps make sure that people can take part in decisions as much as possible. At Austin Rose we saw that information was not routinely made available in accessible formats for people using the service, although we did see that some information was supplemented by illustrations to better help understanding by people using the service.

At the time of our inspection people were living at Austin Rose near the end of their life. We saw there were processes in place to ensure people would receive appropriate medical care at that time. Care records we looked at reflected peoples' choices and preferences regarding whether they wanted to be resuscitated. However, the records contained only basic information about people's end of life wishes, and staff we spoke with did not have further information in this area. The registered manager told us staff were receiving training in relation to end of life care and planned to review the care records when this training had been completed.

Requires Improvement

Is the service well-led?

Our findings

This was the first inspection of this service and in this key area we found that it requires improvement. We have also found that the provider is in breach of Regulation 17.

During our inspection we found that governance and audit systems of the home were not effective. We saw the internal audit systems were being used in the home and noted that some of the areas had not been regularly monitored, such as supervisions of staff. We also saw that when the provider visited the home to check these audits, that this had not been done robustly. For example, during the providers audit of May 2018, we saw that areas such as the dining experience or how deprivation of liberty safeguards were being managed, had not been checked by them.

We saw that supervisions of staff, and training of staff had not been audited robustly. We found that staff had not had regular supervisions and that some areas of their training had not been refreshed. Therefore, staff did not receive sufficient support to carry out their roles well. We saw examples of this lack of support when we saw people experiencing inappropriate and undignified support while being transferred in a hoist. This poor practice had not been identified or rectified by the auditing processes and staff had not received support to assist them to learn.

Auditing had also failed to identify that not all people had contemporaneous or accurate risk assessments to keep them safe. This had resulted in one person experiencing a serious incident with regards to choking. Another person had conflicting information on their care records with regard to their mobility equipment. Records had not been audited well and we found examples of fluid charts not being accurate and no action taken to keep the person safe in light of this.

Systems were not in use that would have identified trends and patterns. For example, accidents and incidents were recorded but trends had not been looked for. Also, there was no active use made of the system in place in the home to monitor responses to call bells. The registered manager advised that whilst there was a method of getting this information from the system, it was not being utilised. We found that the registered manager had not proactively looked for patterns and trends in order to attempt to reduce the likelihood of events recurring.

There were no specific arrangements in place to gather the views and opinions of people, relatives, and professionals about aspects of the service. The registered manager told us that they spoke regularly with people's relatives to seek their views but there was no formal system in place to obtain and record their views. The registered manager could not provide us with examples of where this informal information had been used to improve services to people. This meant that opportunities had been missed to gather and look at feedback to see if any action was needed to improve the quality of the services provided. The registered manager advised us of plans to ensure that all the audit systems would be reviewed and updated on a regular basis to identify any oversights.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the time of our inspection there was a registered manager in place. A registered manager has legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

People and their relatives spoke highly of the registered manager. One relative told us, "One of our other relatives is contacted straightaway if there are any issues, which is reassuring. We have no concerns over the care our relative is getting, we know who to raise any concerns with and we would be confident to do." Staff were enthusiastic about their role in supporting people and spoke positively about the home, the registered manager and the provider. One staff member told us, "The managers support you as much as possible."

There were systems in place in the home that had been introduced to ensure that staff were involved in sharing essential information about the home and the care of people using the service. The registered manager advised that on two or three days each week a short succinct meeting was held between staff and all staff attended handover meetings. Staff advised that this was a good system and it ensured that they were up-to-date with any changes.

Feedback given to us at the time of the inspection from relatives and health professionals described the home as providing a high-quality service. Relatives told us they had confidence in the registered manager and were happy with the way the home was run. They said, "I am confident on discussing any issue with the management if need be."

Staff were aware of and demonstrated their understanding of the provider's whistleblowing procedures. Whistle blowing is when a staff member reports suspected wrong-doing at work. Staff said they felt confident that if they raised any concerns the registered manager would listen and take the appropriate action.

Management and oversight of the premises and building related issues were well managed. Regular testing took place in respect of alarms, hot water, lifting equipment and specialist equipment to support people using the home. The on-site maintenance worker maintained clear records detailing all such systematic testing, and we did not see any concerns with the maintenance of the building.

Our inspection visits and discussions with the registered manager identified that they understood their responsibilities and felt well supported by the provider. The registered manager had kept up to date with new developments, requirements and regulations in the care sector, by the use of the internet but had not yet established contact with local key organisations or stakeholders and agencies.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The registered manager had ensured that effective notification systems were in place and staff had the knowledge and resources to do this. The registered provider regularly visited the home to oversee how the service was being run.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found that the management team had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risk assessments in relation to the heath and safety of service users had not been completed competently, and all practicable steps to reduce risks had not been implemented consistently.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The auditing of the service was not effective and did not promote continuous improvement.

The enforcement action we took:

Warning Notice