Prime Life Limited

Stoneygate Ashlands

Inspection report

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Date of inspection visit:
06 April 2016

Date of publication:
21 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 6 April 2016.

Stoneygate Ashlands provides accommodation and personal care for up to 37 people. The home specialises in caring for older people including people living with dementia or those who require end of life care. The accommodation comprises individual en-suite rooms, and there were 37 people living in the service at the time of our inspection visit.

There was a registered manager in post. 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 administration of medicines was not consistent. Checks undertaken to ensure medicines were administered safely, were not robust which meant a number of shortfalls not being identified or addressed. Medicines were safely stored, however we noted aspects around the administration and recording of medicines which needed to be improved.

Care planning and risk assessments recognised people's individual needs, and care plans provided detailed information about people's individual preferences. People were encouraged to take part in meetings to review their care plans. Records and observations provided evidence that people were treated in a dignified way which encouraged them to feel valued. Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home had sufficient suitably recruited and trained staff to care for people safely. The environment of the home was safe for people and safety checks were regularly carried out. Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They understood that people should be consulted about their care and the principles of the MCA and DoLS. People were protected around their mental capacity.

People's nutrition and hydration needs were met, most people enjoyed the meals, however some were given choices that they previously indicated they did not like. Risks to people's nutrition were assessed and specialist advice was followed. People were treated with kindness and compassion and we saw staff had a good rapport with people, treating them with dignity and respect. Staff had knowledge and understanding of people's needs and worked together well. People were encouraged to engage in activities though some felt there was not enough to do and were bored. Some people would benefit from one-to-one support which was not being offered at the time we inspected. Staff were responsive to people's needs and understood people's individual requirements so that they could support them in the way they preferred.

People told us they were aware how to make complaints and who they could complain to. The results of complaint investigations were clearly recorded.
The registered manager did not have an effective quality assurance system in place. Records were not

reviewed thoroughly or issues picked up by the current auditing system. The registered manager had an understanding of their role and they consulted with people who lived at the service, people who mattered to them, staff and health care professionals, in order to identify required improvements. Staff were supported and trained for their role.
We found a breach 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.

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

People were at risk from harm as staff did not ensure all areas of the environment were safe. People said they were supported with their medicines, though the administration of medicines was not consistently secure. People prescribed regular pain relief did not have their pain levels formally monitored, and we found that written instructions to ensure medicines were given accurately were not always in place.

Care plans and individual risk assessments were sufficiently detailed, to inform and guide staff to provide people with safe care.

Plans to be used in emergency situations were readily available. The employers recruitment process ensured people were safe to work in the home.

Is the service effective?

Good

People felt staff looked after them properly and were trained and supported to enable them to care for people safely and to an appropriate standard. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005. Staff offered people choices and obtained people's consent before offering personal care. People received appropriate food choices that were served in a place of their choice, and this provided a well-balanced diet that met their nutritional needs.

Is the service caring?

Good

People told us staff were caring and kind and recognised their privacy and dignity. People were encouraged to make choices and were involved in decisions about their care and staff gave people reassurance when they needed it.

Is the service responsive?

Good

People received personalised care that met their needs, and staff had back up information that supported this. People received a service that reflected their cultural heritage, though it was unclear people were engaged in meaningful activities.

People told us they would have no hesitation in raising concerns or making a formal complaint if or when necessary.

Is the service well-led?

Requires Improvement

The provider used audits to check people were being provided with good and safe care, however these were not thorough and did not reveal a number of areas that compromised people's safety.

People using the service and relatives had opportunities to share their views on the service. Staff had high praise for the management team told us they were approachable and helpful.

Stoneygate Ashlands

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 6 April 2016 by one inspector and a specialist adviser and was unannounced. The specialist advisor who supported us on this inspection was a qualified nurse with experience of supporting people living with dementia.

Before the inspection visit, we looked at our information systems to see if we had received any concerns or compliments about Stoneygate Ashlands. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

The provider had not sent us 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. On this occasion the provider was not asked to send a PIR before we visited.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spent time observing the care being provided throughout the home. We observed people being supported at lunch time and at other times in the home. We spoke with three people using the service, a visiting relative, the registered manager, administrator, two care staff, cook and cleaner.

We looked at four people's care plan records to see how they were cared for and supported. We looked at

other records related to people's care such as medicine records, daily logs and risk assessments. We also looked at quality audits, records of complaints, incidents and accidents at the home and health and safety records. We also looked at records relating to aspects of the recruitment and staffing, as well as policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said care staff supported them with their medicines. One person told us, "They give me my tablets, I don't want to look after them at my age, I might forget." Another person said, "They always ask if I need pain killers, it's for my knees." The care staff who administered medicines had received training and we saw they correctly followed written guidance to make sure that they administered medicines to the right people. Staff were trained and regularly had their competency assessed by a senior manager.

Medication Administration Records (MARs) were in place for each person and detailed with a photograph and any allergy information. However not all MARs for people in receipt of 'as required' medicines (PRN) had instruction when, or under what circumstances staff should offer these medicines. There were also no separate charts for the application of prescribed topical creams, to ensure this was applied consistently in the correct area. The MAR chart did not state where the cream should be applied only stating 'as directed' which did not ensure staff's awareness.

We saw and heard people were offered pain relief, however we found examples where people's pain was not sufficiently monitored. For example, one person was prescribed paracetamol four times daily which was not being given regularly. Staff said to us this was to be given 'as required'. However this was not indicated on the MAR chart. Staff were not monitoring the person's pain, and not asking if they required their pain relief medication. Another person's pain relief was increased from twice to four times a day. There was a hand written amendment to the prescription which was not signed by two staff, which is the home's own policy. That meant staff were not following the policies and procedures laid down by the provider.

Storage of medicines was secure, and staff monitored the temperatures to ensure they remained potent and effective. However, we found there were two days in the week prior to our visit, where no room temperature had been recorded. We spoke with the registered manager who said he would ensure daily checks would be completed, and there was a sufficient supply of medicines in stock and the disposal of medicines was safe.

When people were gathering for lunch we noted all had free access to the servery. This was extremely hot, but there were no warning signs advising people of this, and no way of keeping people at a safe distance so that there was a risk to people from the uncovered and unprotected equipment. We asked the registered manager, who confirmed no risk assessment had been done. A risk assessment was forwarded to us following the inspection which included information for staff to keep the dining room doors locked to ensure people remained safe.

The main meal is not cooked in the home, and is brought in from a central kitchen. This is a commercial kitchen which produces meals for a number of homes owned by the provider. We spoke with the catering staff who ensured the food was at a safe temperature before it was served. We saw records of this and of the fridge and freezers temperatures that were regularly monitored. Food stored in fridges included a date when it was opened, which meant staff could ensure it remained within date and was safe to serve to people.

Care staff were aware of the safeguarding and whistleblowing policies and those spoken with said that they

felt enabled to raise concerns with the registered manager or their deputy. They also told us a director of the company visited periodically, and felt they could raise concerns with them as well. There was whistleblowing information available for staff in the home. That included the company's own whistleblowing telephone number as well as external contact details of the local authority and Care Quality Commission. This meant that staff could alert outside agencies if they suspected people were being abused and their concerns were not being dealt with by the homes' management.

People told us they felt safe, one person said, "I am safe here, I lock my (bedroom) door." Care staff were confident that people were safe from harm and said they would report any concerns of abuse to a senior person at the service. They were aware how to contact external agencies such as the local authority safeguarding or CQC and said they would do so if they continued to have concerns. The provider had policies and procedures to back up the training care staff received on safeguarding and whistleblowing. Records showed that care staff had completed training on how to keep people safe and staff spoken with confirmed they had been provided with relevant training and guidance.

There were systems in place for the maintenance of the building and equipment. However there were no fly screens to the windows in the kitchen. We spoke with the registered manager who said these had been taken down for cleaning and not yet replaced, and he would have these replaced immediately. Records showed equipment needed to support people such as hoists were maintained and regularly serviced. We spoke with staff who told us they were trained in moving and handling techniques, which we confirmed with the training matrix.

Staff were aware of the reporting procedures for accidents and incidents that affect the health and wellbeing of people. Records showed that staff documented incidents including any injury, signs of pain and the actions taken. Records confirmed that staff had sought medical advice where a person had a fall or expressed pain. We saw that staff continued to monitor people's wellbeing following any such incident or accident.

We saw that two people's wheelchairs had no foot plates. Staff reported that they were able to self-propel themselves and this had been risk assessed and was in the care plan. We looked at the care records and this was evidenced, however another wheelchair in the dining room also had no foot plates. The home must ensure that people were only transported in wheelchairs specifically designed for the individual. Moving people in wheelchairs without using foot plates increased the potential for injury and accidents.

Information on people's mobility in the event of an emergency was available; however this was not always up to date. Personal emergency evacuation plans (PEEPs) did not reflect people's current mobility needs. One person's care plan recorded that they required assistance and their mobility risk assessment stated that they used slide boards and a wheelchair. There was no information of this person's needs located where the PEEPs were held.

Assessments for people who were at risk of falls, mobility, nutrition, developing pressure damage and choking, had been undertaken and most of the records we saw were updated regularly. When we spoke with care staff about the risk to people they knew about and were able to explain the identified risks. Care staff were able to explain how to keep people safe.

Care staff told us and we saw there were sufficient numbers of staff on duty for people to stay safe and be supported with their daily needs. The registered manager told us that they assessed the staffing levels in the home and were confident that staffing numbers could be increased if people's needs changed. They told us they planned the level of staff in line with the needs of people and the staff skills. The staff rota was reflective

of the staff on duty. It showed that the staffing levels were maintained with five care staff in the day with the support of the senior carer or deputy manager and three care staff and senior carer at night with the management team providing the on-call support. A person living at the home said, "I love to sit and chat with them, there used to be four, now it's five it's much easier."

Good

Is the service effective?

Our findings

People were happy with the staff that supported them and felt staff understood their needs and how they liked to be cared for. One person said, "The staff are very good. They know what to do but will always ask."

Staff told us that they commenced their training with an induction programme and then had access to courses relating to their role in health and safety, manual handling and food hygiene and infection control. We confirmed the induction programme by speaking with and looking at the records of a newly started care worker. The registered manager confirmed the staff induction training and on-going training were linked to the care certificate, which is a nationally recognised training course.
Our observations confirmed that staff put their training into practice. Staff used hoisting equipment correctly whilst they kept the person informed to what they were about to do, guided them and provided reassurance throughout the process.

Some staff had already attended 'virtual' dementia training and other staff were booked on the course. This a training approach using specialist IT equipment to enable staff to experience what it feels like to live with dementia and can add in other sensory difficulties such as impaired hearing, visual difficulties and verbal communication barriers. Staff told us about the training, and how it highlighted the difficulties that people living with dementia experienced. We confirmed the staff training with the training matrix supplied by the registered manager.

Staff felt communication and support amongst the staff team was good. The daily handover meetings provided staff with information about people's health and wellbeing. Staff also told us they felt supported through the regular staff meetings and supervision meetings with their line manager.

The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

At this inspection we found evidence of mental capacity assessments for individuals and best interest assessments. Where people were unable to make decisions themselves, the correct procedure had been followed to protect their rights under the Act. There was a form in place for assessing people's mental capacity. We found that the registered manager had ensured that people were protected by the DoLS. Records showed that they had applied for the necessary authorisation from the relevant local authority.

Staff offered people choices and sought consent before they helped them. We looked at the home's meal provision and how staff assessed that people received a nutritious and healthy diet and weight. The meal

came ready prepared from a central kitchen, and was delivered at a time for the main meal to be served at 12.30pm. People told us they were happy with the meals provided. One person said, "The food is good, it's hot and there's plenty of it." Another person said, "The food is very good here, I don't mind what it is". However one person said, "There's room for improvement, like having vegetables in dishes, they put it on the plate and there are some I don't like." Menu preference questionnaires were in care plans and included people's likes and dislikes. There was information in the kitchen about people's dietary requirements but this did not include people's individual dislikes. Meals were plated when the lunch time meal was served. We discussed this with the registered manager who stated he would ensure the staff updated people's likes and dislikes, which would allow people to be offered meals to suit their taste. The registered manager also agreed to look at how to promote people's independence by offering vegetables in dishes to promote people's choices.

People living with dementia were supported to choose a meal to suit their taste. We saw that some people were offered the choice of two plated meals, where they could not choose from the menu. Where required following assessment, charts to monitor food eaten and weight monitoring charts, were in place for people when they had a weight loss or special dietary requirements. Catering staff were able to show us who required fortified drinks, and we saw these being offered to people. Records showed that an assessment of people's dietary needs had been undertaken. Where required, people were referred to their GP, speech and language therapist (SALT) and the dietician. That ensured any meal supplements or changes to their dietary consistency was managed in line with professional guidelines. Staff described how they supported one person which showed that they followed the advice recommended by SALT team. Staff monitored how much a person with a poor appetite ate and drank. Records showed how much the person should eat and drink as a minimum. The registered manager said if he had concerns about anyone monitored this way, he would seek further medical advice if concerned about the person's health.

People were asked if they would like to eat in the dining room, lounge or their bedroom. We observed staff helped people that required assistance to eat their meal. This was done at a pace to suit the person, and staff were positioned to enable good eye contact. The atmosphere at lunchtime was relaxed and staff supported people to eat without rushing them. Staff were attentive and responded to requests when people wanted second helpings or assistance with cutting their dinner into smaller pieces. We saw all staff maintained friendly conversations with people throughout the meal. Fluids such as water and cordial were freely available in communal areas with fresh fruit and snacks which was in addition to regular hot beverage rounds provided by care staff. Staff were observed to give choices to people including prompting to maintain the ability to eat independently.

However, we saw that some practices did not support people living with dementia as the information was confusing. The meal on offer at lunch on the menu chalk board located outside the main dining room was unclear, with a mixture of breakfast and lunch time choices on it. A printed menu in the dining room menu book had the wrong day selected.

People told us their health and medical needs were met. They told us staff would call the GP if their health was of concern. People's care records showed that people received health care support from a range of health care professionals and attended routine medical appointments.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person told us, "I have been here three years, the staff are nice and friendly." We saw a number of positive interactions between staff and people living in the home. For example, staff that assisted people were aware of their needs and assisted them at a pace without trying to hurry them.

People were able to complete their meal in an unhurried manner. We heard one member of staff explaining they needed to assist a person in a wheelchair. This was done in a caring and unhurried way giving the person time to follow the instructions by the staff. We observed staff greeted people in a friendly way when entering communal areas and people were given the choice of where to sit when taken into a communal lounge.

We observed staff were caring and showed compassion towards people. Staff were kind and attentive when they supported people. Staff spoke with people and prompted conversations on topics that were of interest to them. One staff member described knowing about a person's life history, the work they did and family life had influenced how they supported this person. For instance, it was important for this person to be dressed well which made them feel good about themselves.

We saw staff reassured one person who was upset, by gently stroking their hands. This worked and calmed the person. Staff took care when they supported people and knew how to assist them to move around. Health care professionals we spoke with during the visit told us that they found staff to be caring, kind and knew the needs of people they supported.

People told us that staff checked that they were comfortable throughout the day. Care records we looked at demonstrated that people had been involved in the development of their care plan. Individual choices, preferences and the decisions made about their care and support needs were recorded. The daily records about the care and support people received showed that staff respected people's decisions about how they were supported and their lifestyle choices.

Staff understood the importance of respecting and promoting people's privacy and dignity, and took care to preserve this, when carrying out their duties. We observed staff sought consent where people required support with personal care and heard to knock on bedroom doors and identified themselves on entering the room. One member of staff said to us, "Dignity is a big part of caring, making sure we respect their wishes as well."

They gave examples of the steps taken to maintain people's privacy and dignity when they supported people their personal hygiene. We also saw examples of this when staff used a hoist to transfer a person from a chair into a wheelchair.

All bedrooms were en-suite, and additional toilets helped to maintain and promote people's privacy and dignity. Staff told us that people were offered a bath or shower and that staff respected their wishes and the

care records we looked at confirmed this to be the case.

Good

Is the service responsive?

Our findings

People told us that staff looked after their care and health needs. One person told us that the staff understood their needs, and said, "[named staff] knows which way I like to lie in bed, and how my pillows are arranged."

People told us they received the care and support they needed to maintain their daily lives. One person who we spoke with, confirmed they were involved in decisions about their care and we saw that they had signed their care plan and risk assessments.

Care plans were personalised, for example we found one person chose not to receive cultural or religious support from the home and their meals were provided by their family members. We spoke with the registered manager about this. The home had been selected by the person and family based on the facilities the home provided, and they continued to be happy with the service provided. People who were able, were involved in reviews of their care plan, so that they had the opportunity to discuss and agree the care on offer. Reviews took place most months and whenever a person's circumstances changed and were carried out by people's keyworkers and a senior carer or manager.

People had communication passports for use on transfer or admission to other services. Some of these had been produced from a document called, 'Getting to know me' which was compiled when people were introduced to the home. However this information was not used consistently to personalise all care plans we reviewed. That meant some information may not be available for staff, and reduce their knowledge of people prior to coming into the home.

Staff were responsive to changes in people's health needs and promptly sought medical advice and ensured that preventative medical interventions were available. For example, the annual flu vaccination, opticians, chiropody and dental visits, and people were able to choose in house or community appointments.

It was not clear how people were stimulated or engaged in meaningful activities according to their needs and wishes. One person told us, "Little goes on in the home, there's no action" and "You just sit in your room all day." There was no evidence of activities available to people who chose to remain in their room, which would have reduced their social isolation. We did not see any activities were available for people living with dementia. People living with a dementia often have communication barriers to engage in group based activity and often benefit from individual one-to-one sessions using personalised memory books or photographs about their life.

We spoke with the registered manager about this. He said that the activity planner was about to be changed to a summer timetable. That would include time for people in the garden, barbeques and gardening club, as well as the on-going pampering and entertainment that was currently on offer. The registered manager said he would look at what could be put in place for people who preferred one-to-one help.

Staff told us there was an activity programme in place, although we did not see one displayed in the home.

We observed people reading daily papers, though this did not stimulate discussion between the people or passing staff. We did not see any people being supported to engage in activities.

People we spoke with told us they knew they could raise concerns with their keyworker, registered manager or deputy. The registered manager explained there was a weekly management 'surgery', which meant that he or his deputy manager were available to speak with people, should they wish to discuss any concerns or require a general discussion.

The service had a complaints policy. People could make complaints verbally or in writing to the registered manger or directly to the provider's head office. The procedure explained how the complaints process was operated and the time frames involved. The procedure explained who people could take their complaint to if they were not satisfied with the response. We saw six complaints had been received in the last 12 months, and these had been responded to in line with the complaints procedure which included a response to the complainant to ensure they were satisfied with the outcome. Learning from complaints was fed back to staff through staff meetings or individual supervision. One person said to us, "If I had to complain, I would speak with Maureen [deputy manager]."

Requires Improvement

Is the service well-led?

Our findings

There was a system used within the service to monitor quality assurance, however we found that this did not assess or monitor the quality of care effectively, to assure changes. A system to monitor that risk had been thoroughly assessed to protect people from harm and ensure their safety, was not in use. There was no consistent audit system to assess risks to people in the building. We identified areas of risk that had not been identified by the manager or provider. For example, it had not been recognised that the hot food trolley in the dining room posed a risk, and only when we pointed this out was remedial action put into place.

We identified shortfalls in the administration of medicines. There were inconsistencies in the medication administration records (MAR charts) and where people were not given the prescribed amount of medicines. Some people did not have guidance protocols to ensure PRN or 'as required' medicines were administered effectively or consistently and their effects monitored. It is the provider's responsibility to ensure quality assurance is undertaken and people are given the correct medicines.
We noted there were first aid kits placed around the home, though these had not been replenished with the necessary equipment to ensure people were treated promptly. There was no delegated responsibility to ensure these were checked regularly. The registered manager was unaware these needed to be replenished which meant people may be placed at risk from emergency equipment which is not checked and replenished.

Individual personal evacuation plans (PEEPs) were not up to date, or included in the business continuity plan and there were no evacuation details readily available for use in an emergency. This was not identified by the internal auditing process and could put people at risk, through a delayed evacuation of the building, with potential serious consequences.

A Director of the company visited to monitor improvements and provide people with an opportunity to make comments or raise concerns directly. These visits were undertaken on a regular basis and covered areas of quality assurance where the provider looked at an overview of care planning and health and safety. These were not comprehensive enough to reveal any shortfalls that we found during our inspection.

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

We saw there was a way to ensure people's personal allowances were administered safely and securely. The administrator had developed a system that was checked periodically by one of the management team and an auditor from the company head office. We checked six people's individual monetary transactions which were all correct.

The registered manager told us the provider issued annual questionnaires to people using the service and their relatives and these had just been sent out. The registered manager and deputy worked flexible hours to ensure they had an overview of how the service ran on different days and at different times. They also

supported staff by providing an on-call system, so staff could contact them for support at any time.

Staff had high praise for the management team. One person said they were supportive and would assist them with any issues that arose. They also confirmed there were regular team meetings and said, "The office door is always open and there is someone on call out of hours." Another said, "Yes I do feel supported. We have supervision every two months and meetings at other times." Staff were aware of the out of hours on call system.

There was a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. Staff were aware of the process for reporting faults and repairs. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained. The management team also had access to external contractors for maintenance and any emergency repairs.

We looked at the record of safety tests undertaken in the home. These were completed by the Prime Life's 'estates team' from the head office. The periodic testing of gas appliances and electricity supply were up to date and were performed by appropriately qualified engineers. There was a business continuity plan produced by the provider. This had information for staff in the event of a significant failure of part of the building, water, gas or electrical services. That meant staff had essential information they could use in the event of an emergency to immediately arrange any remedial action.

The service had a registered manager in post and there was a clear management structure within the home. The registered manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. The registered manager notified the Care Quality Commission of events they were required to report. These included accidents and incidents that affected the people living in the home and staff group. They also had arrangements in place that ensured notifications would be forwarded when they were not in the home.

Staff demonstrated a good understanding of their roles and responsibilities and knew how to access support. Staff had access to people's plans of care and received updates about people's care needs at the daily staff handover meetings. There was a system to support staff, through regular staff meetings where staff had the opportunity to discuss their roles, training needs and they could discuss how the service was changing. Staff told us there was staff supervision in place, but some staff had not received recent sessions. We spoke with the registered manager about this who said he would ensure these were brought up to date, and sent us a plan to confirm this.

Staff told us that their knowledge, skills and practice was kept up to date. We viewed the staff training matrix, which showed that staff had updated refresher training for their job role and training on conditions that affected people using the service such as dementia awareness and behaviours that challenge.

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 17 HSCA RA Regulations 2014 Good governance Systems and processes did not effectively assess, monitor and improve the services provided. Systems had not been established to monitor and mitigate risks related to people's health and safety.