Golden Age Management Limited

Attwood's Manor 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

Overall summary

The service is registered for 65 people over the age of 65.

We last carried out a comprehensive full ratings to this service on the 08 July 2015 and the overall rating was good with requires improvement in safe. Previously on the 16 and 26 January 2014 we had rated this service inadequate and the provider had worked hard to improve the service.

We received some information of concern so carried out a responsive inspection to the service on the 20 November 2015. During this inspection we looked only at medicines and found significant concerns about how people were receiving their medicines. As a result of this inspection in November we took the following actions. We rated safe as inadequate and served two notices. The first stated: The registered provider must not admit any further service users to Attwood Manor Care home without the prior written agreement of the Commission. This was put in place until the service could demonstrate how they had improved their practice specifically in relation to medicines. A second notice required the provider to employ a suitably qualified person to oversee the

Summary of findings

management of a safe medication administration system compliant with the regulations and the available, appropriate guidance. We have since received an action plan telling us how the provider has addressed our concerns.

Because of the concerns we had during our responsive inspection we carried out a full rating inspection on the 14 December 2015 and saw that the home had made improvements in the way they managed and administered medicines for people. We subsequently met with the provider and lifted the notice served on the service in regards to new admissions. .

There is a registered manager in post but the manager was off for period of time and the interim manager had also left just prior to our responsive inspection on the 20 November 2015. '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.'

Throughout our observations across the day we saw that some people were engaged in set activities provided by the activities coordinator and member of staff which included nail painting and singing and dancing to music. Some people spoken with said there were not enough activities or activities which suited their individual needs so we were not assured that activities were appropriate for everyone and we noted some people sat throughout the day with little to engage them.

Risks were not always effectively managed and we identified a number of areas of concern and restrictive practice. People told us they were not always free to come and go as they please because it might not be safe for them to do so and individual risk assessments did not always clarify the risk and the subsequent restriction.

Medication practices were much improved since our last responsive inspection in November 2015. We were confident that staff administering medications were competent and medicines were stored, ordered and administered safely. We have raised a few minor concerns which need attention.

Infection control procedures could be improved as unpleasant odours were noted in the service and deep cleaning could be improved.

People were supported to eat and drink and this was monitored to ensure it was adequate for their needs. Staff had taken on board what they had picked up on a recent nutrition course and people were being encouraged with their diet and given additional milky drinks, jelly and snacks. However some people were not given the support and encouragement they needed and records did not always accurately reflect what people had to eat and drink.

Staff were supported and they received supervision and training. We observed some caring practice but this could be improved upon by more direct observations of practice to ensure all staff were working in a professional, respectful way.

The home had an adequate complaints procedure and took into account what people wanted and how they wished the home to be run. However we found the care provided to people was not always centred on their needs or uphold people's dignity, or independence.

Care plans were in sufficient depth and were being planned around people's needs and kept under review but were not always accurate.

The home had a recent change in management and were making steady progress but we identified areas of improvement which had not been identified by their own internal quality assurance processes. This meant the home was not always safe or run in people's best interest.

We found one 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 this report.

Summary of findings

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 home was not always safe.

Staffing levels were not always considered in line with people's individual needs or deployed effectively to ensure people's needs and wishes were met.

Risks to people's safety were generally well managed but a number of environmental risks were identified.

Cleaning and infection control required improvement.

Staff recruitment procedures were adequate.

Medication practices were sufficiently robust.

Is the service effective?

Requires improvement

The service was not always effective.

Restrictions placed on people were not always the least restrictive and we could not see a clear rationale to impose these restrictions other than to minimise risk at the cost of promoting choice and independence.

People did not always get the support they required with eating and drinking

Staff training was provided to staff but we were not confident it was of sufficient quality and helped staff provide care based on best practice.

People's health care needs were adequately met.

Is the service caring?

Requires improvement

The service was not always caring.

People's experience varied across the service and some staff were reported to be more responsive to people's needs than others.

People's dignity and independence was not always upheld.

People were consulted about their needs but we could not always see that the care given centred around the needs of individuals.

Is the service responsive?

Requires improvement

The home was not always responsive.

Activities were organised throughout the day to help keep people stimulated and occupied but the range and times activities were provided did not meet everyone's individual needs.

Care records were generally of a good standard but there were some inconsistencies in record keeping.

The service had an effective complaints procedure.

Summary of findings

Is the service well-led?

The service was not always well led.

There were interim management arrangements in place and the home appeared to be running well. However we found some areas requiring improvement which had not been identified by the homes own internal audits.

Gaps in staff training and the limited direct observation of staff practice had led to variable staff practices.

There were some issues with the safety and security of the building which posed a breach and risk to people's health and safety.

Requires improvement

Attwood's Manor Care Home

Detailed findings

Background to this inspection

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

The inspection was unannounced, and took place on the 14 December 2015. The inspection team included four inspectors.

Prior to the inspection we reviewed all the information we already held about the service including the most recent inspection and the provider action plan, information from whistle-blowers, and notifications which are important events the service is required to tell us about.

We spoke with three care staff, domestic staff, administrative staff, activity staff, and catering staff. We spoke with the deputy manager, Care Co-ordinator, senior staff and team leader. We spoke with a visiting social worker. We spoke with twenty one people and case tracked five people. We did a medicines audit and looked at other records including staff files, staffing rotas and other records for the running and management of the business.

Requires improvement

Is the service safe?

Our findings

We made a judgement about whether there were enough staff on duty by talking to people using the service who could reliably tell us about their experiences. We also carried out observations in the communal areas throughout the day to capture the experiences of people who could not tell us about their experiences.

One person told us, "There isn't really enough staff, I don't use my buzzer very often, but staff come when I press it in the end." Another person when asked if there were enough staff said, "Definitely not, staff do not have time to chat and there's lots of agency staff at the weekend." Another person told us they needed help with all their needs and said, "Staff answer the call bell eventually, but you do have to wait." They told us the previous night they had pressed the call bell four times before it was answered. They said they are short staffed.

Of the staff we spoke with most felt staffing levels were adequate and agency staff were only used to cover staff sickness. Staff felt there were enough staff when staff pulled together and worked as a team.

People were not adequately supported throughout the day. This was evidence at lunch time when insufficient staff were redeployed to support people with their lunch time meal. this resulted in people waiting an unacceptable amount of time, up to fifty minutes and some people leaving the table before completing their meal without staff noticing or offering encouragement to ensure people ate as much as they wanted.

The home had implemented a dependency tool which helped the manager determine how many staff they needed in line with people's individual needs. However this was not available to us during the inspection as it was locked in the provider's office. It was not clear how staffing levels were reviewed in accordance with this tool. For example there were times on the staffing rotas where staffing numbers dropped below what the provider said they needed. There was also a reliance on staffing working additional hours to cover shifts. At the time of our inspection there were no recorded night audits so we could not see how the provider assured themselves that staffing levels were adequate and unplanned reductions to staffing levels did not adversely affect the service. The provider told us they often stayed at the service in separate accommodation so could monitor; night practices' but was unable to demonstrate how they do this.

There were a number of people with significant bruising from recent falls and we observed minor altercations between people using the service which could increase risk to people's health and safety. However during our inspection people received frequent supervision and staff were good at intervening into potentially difficult situations. However we were not confident this was always the case and people using the service told us and we saw from the staffing rotas there were not always enough staff.

We observed care provided to people and looked at people's records. We saw that there were a range of risk assessments in place for people which told us what the identified risk was and what measures were in place for people to control the risk. Including for (falls/mobility issues) malnutrition and screening tool, MUST); Infection control, constipation risk and dependency level. There was evidence of review but not all the information married up so we could not be sure of its accuracy. For example a manual handling assessment said no falls this year whereas the falls risk assessment indicated several falls.

We found some practices in the home were restrictive without a clear rationale for this. For example a number of people smoked and their cigarettes were kept by staff and people had to ask when they wanted one and then staff accompanied them outside when they had time. The rationale for this was based on one previous incident which almost resulted in a fire in the person's bedroom. The home had not assessed the risk to each individual but had come up with a decision affecting everyone as a means of controlling risk. Whilst at the home we saw risks relating to fire safety were not being adhered to by staff. This posed as much risk to people as their individual behaviours. For example we saw that a fire door was not closing properly, this meant there was no effective seal around the door. Another fire door was propped open despite a notice stating fire doors should be shut at all times. Fire exits were being used to store wheelchairs causing an obstruction

This demonstrated a Breach of regulation12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment which states the premises and any equipment used is safe.

Requires improvement

Is the service safe?

Infection control procedures were not sufficiently robust. We spoke with a number of staff responsible for laundry and cleaning. The house keeper was off sick. Staff were confident in the processes and told us they had completed infection control training and were knowledgeable about infection control. However in parts of the home there were unpleasant odours. We spoke with the acting manager about issues round continence and they assured us they worked closely with incontinence advisory service to support people around their incontinence but this did not distract away from the fact that smells were not confirmed to one area of the home.

We found the dining room unclean; the floor was dirty and sticky just prior to lunch, fire extinguisher were dirty, covered in grease and dust.

There were adequate safeguards in place for people using the service. There was information available for staff to tell them how to recognise abuse and what actions they should take if they felt a person was at risk of abuse or harm. The staff training matrix showed that staff had received basic training on safeguarding people from abuse. We spoke with staff about what they would do if they suspected a person to be at risk or harm or abuse and they demonstrated sufficient understanding of what to do and who to report concerns too. Staff were confident senior staff would act upon their concerns.

New staff were vetted before employment. Recruitment procedures for new staff were adequate. We checked a number of staff files and saw that staff had appropriate checks in place before they came to work. Checks were designed to assess their suitability for this work and to ensure they did not have a criminal's record which might make them unsuitable to work with older people. Job applications were received, and staff interviewed, and references sourced and checked. An agency profile was in place for the agency worker on duty on the day of inspection and showed they had suitable training and experience.

People received their medicines safely. We noted a clear improvement with regards to the administration of medicines since we last inspected on the 20 November 2015. Information regarding the storage of eye drops was now available for staff and liquid medication and eye drops were correctly stored. Medicines prescribed as necessary were being managed correctly. There was still no additional information for staff about the medicines people routinely take or medication profile but the service informed us they were working on these things.

We noted that people had the medicines records they should have but found one person had one fewer antibiotic tablet than they should have. This suggested they may have been administered an additional dose as there was no record of any tablet being dropped and we could not find any dropped tablet in the bottom of the medication trolley. Staff had continued to sign as if they were counting the remaining tablets even though the tablet count was incorrect. Staff had carried out the most recent count that morning and had just subtracted one from the last recorded number and did not actually count the tablets. This poor practice places people at risk.

Warfarin records were correct and information about the administration of Warfarin was clear and available for staff to refer to. The placement of Buprenorphine patches was being recorded on body maps but one we saw just alternated weekly between two sites which did not leave sufficient time (3 to weeks as per the manufacturer's instructions).

Some discontinued medicines still remained in the trolley which could have been confusing for staff. The trolleys were still rather muddled and needed to be tidied up to make it less confusing for staff

The medication room had temperatures recorded and had been reorganised. Medicines ready for disposal had been clearly recorded in the book the service used and signed by two members of staff. Since our last inspection a best practice booklet had been provided for senior staff. This included scenarios to test staff knowledge and NICE guidelines for staff to refer to. Two of the senior staff who administer medicines had already completed this. We briefly observed lunch time administration and this was done safely and appropriately.

Requires improvement

Is the service effective?

Our findings

Improvements were required in how people were supported to make their own decisions about their care and welfare and how their needs should be met. We spoke with staff and found gaps in their knowledge in relation to relevant legislation around the Mental Capacity Act 2005 and Deprivation of Liberty safeguards, Dols. It is essential staff had a basic understanding of this to help them to understand how they should support people lawfully.

We found the environment restrictive in a number of ways including bedrooms being locked when people were not occupying them. Staff told us this was because otherwise some people using the service would go into other people's rooms. It was not clear how the home had taken the least restrictive step to minimise this. One person told us that at night when they were in their room people would walk in uninvited. Staff told us people were asked if they wanted a key to their room and this was documented. We did not see this in people's care plans. Staff said if people were deemed to lack the mental capacity to look after a room key safely they were not given one. We spoke with people about restrictions in the home and some people raised concern about having to wait to go back to their room. This diminished their choice. Another example was a person who told us they were unable to control/change the television programme as the controller was held in the office. We were subsequently told that remotes were available in the lounges but people using the service did not know this and we were not told this when we asked for the main remote on the persons behalf. Another person said they wanted to go out but staff were not available to take them out. We were told staff take people out when they had time but this meant people were restricted and they could not go out when they wished. A person told us staff were 'busy' and they would have liked to go out. We did not observe staff being available to provide people the opportunity to go out when they wished.

We noted the dining room was shut following lunch with no justification to do so.

Care records did not always include mental capacity assessments when we would expect to see them and a number of records gave conflicting information about a person's capacity.

We spoke with five staff. They felt well supported and told us they received regular one to one supervision. They also said there were staff meetings and their ideas were listened too. The acting manager said annual staff appraisals were being carried out for all staff.

Staff training records were not produced in their entirety as most of the records were locked away in the provider's office. The deputy manager told us some staffs training had not been updated as required and this was being rebooked to ensure all staffs mandatory training was up to date. A team leader on nights had been given the responsibility to ensure all staff training was up to date but the fact this had lapsed for some staff demonstrated insufficient oversight. Staff spoken with were not up to date with all their training. One staff member told us they had not had dementia training although they had been at the home for three years, some staff had received training but this was not consistent across the staff team. Some staff had not received any training around the specific needs of people using the service such as: mental health, catheter care, Parkinson's or diabetics. Some staff had but it was not clear how staff shared their knowledge and good practice so for example having staff champions for key areas of practice. We asked one staff member about DoLS and MCA and they told us, 'Oh that's for seniors.'

We found the main but not exclusive way for training to be delivered was through a series of videos staff were required to watch and then to answer questions pertaining to what they had seen to demonstrate their understanding of it. Through our observation of staffs care practices we could not see how good care principles were always embedded into practice. For example we noted staff transferring a person from their wheelchair to armchair without asking them or telling them what was about to happen by pulling the footplate to move their wheelchair. We saw staff not upholding people's dignity and pulling people backwards in chairs without explaining first what they were doing. We saw care practices were based around routines rather than individual need. For example people being assisted to the toilet before lunch rather than at different times of the day. The acting manager said they worked alongside care staff but there were no observations of staff practice to help identify any poor practice other than for manual handling practice and medication practice. If this was in place it would help the home demonstrate how they support staff in terms of good practice and in ensuring they had the right competencies and skills.

Requires improvement

Is the service effective?

Most people were happy with the food but we were not assured that people were protected against the risks of malnutrition and dehydration. One person said "The food is variable, not a lot of choice really." Another person told us they did not always like the food and the alternatives were limited so relied on family to bring foods in. Other people told us the food was fine and they particularly enjoyed the cooked breakfasts which were made available each day. In addition the provider told us they completed food satisfaction surveys, and asked people about their food choices and preferences which were recorded in their care plan. They also provided choice at each meal and accommodated people's dietary needs as far as it was reasonable to do. The chef said there was an extra budget for Christmas.

We noted some really positive practice around people's nutritional intake. Some staff had been on a training course about nutrition in the elderly. The chef although very knowledgeable had not been enrolled on the nutrition course and neither had the other catering assistants. A number of things had been implemented since staff had attended the course including supplementary foods such as pots of jelly and home-made milkshakes for those identified at risk of malnutrition or dehydration. In addition people were offered milky drinks at night and supplementary foods like soups. There was a list of people whose food was to be fortified to give them additional calories.

We were concerned that fluid records were not accurate. Most records indicated that people had received 200 ml's per drink but records did not seem to take into account that some people had not finished all their drink. We saw that records were put on to the computerised system and there was some monitoring of what people were eating and drinking. However there records were not reliable. We saw records of people's nutrition and a shaded plate to indicate how much a person had ate. However these did not always record what a person had eaten, the amount or where a person was refusing food we could not see what actions staff took. The nutritional record did not include evidence of snacks but there was separate records for supplements and another for fluids. This was confusing and meant staff when evaluating records had to look at a number of different records, none of which were complete.

We looked at people's weight records. Everyone was being weighed monthly even when people had a very low weight or had lost weight recently. It was difficult to see if people were adequately supported with nutrition or if the additional measures taken to improve people's food/fluid intake were effective because of fluctuations in records. There was not always a weight recorded and we saw differential recordings of people's height so concluded that the records were not reliable.

Record keeping did not reflect the efforts of staff to try and adequately support people's nutrition and hydration needs.

We observed people having lunch and saw that staff did not promote people's choices as much as they could. For example food was put down in front of people without explanation. Jugs of juice were available of different flavours but people were not asked what flavour they would like, staff just put one jug on the table. We noted that some people did not have salt/pepper/sauces on the table. The explanation given for this was that some people living with dementia might throw them thus causing injury to others. We were told risk assessments had been completed for this. We felt this was unnecessarily restrictive and showed people were not given support according to their individual need. If a person was identified as likely to throw things causing injury there should be a more proportionate response such as ensuring they received adequate supervision at lunch time to promote their safety and independence. The provider said people only had to ask if they wanted salt and pepper without acknowledging that some people might not be able to do this.

People's health care needs were met. People told us that staff ensured they have medication for pain if they need it. One person told us they took care of their healthcare needs as much as they were able "I only have help with it in the night." Another confirmed their health care needs were met. They said they had recently seen the chiropodist, staff did their finger nails and the optician had recently visited.

The acting manager said they got good support from the nurse and GP practice. They said there was some times a delay in mental health support as they were working with more than one service in different locations. We also noted a person was discharged from hospital without a discharge note and medication which was not clearly labelled. The acting manager immediately dealt with this situation and said it was not the first time it had occurred and should consider raising a safeguarding alert.

Requires improvement

Is the service caring?

Our findings

We identified some really positive practice and saw most of the staff were knowledgeable about people's needs and were caring. However some people told us staffs responses to them could vary from staff to staff so good practice was not universal across the whole team. One person said, "Some are better than others. " Another person said," Staff are good bad and indifferent, there are a couple of staff who leave a lot to be desired." Another person told us, "The staff are very nice, but some are not very patient." Another person told us that they did not always get the help they needed from staff and didn't like living at the home. They said they felt isolated. During our observations this person was isolated in the main lounge and not encouraged to join in activities. At lunch time they were sat by themselves and had minimal interaction from staff. They told us they just waited for visits from their family. When we spoke about this person to staff they said,' Oh they have dementia,' We were able to establish quite easily what this person liked and did not like and they were able to describe their isolation. They said staff did not spend enough time with them and this is what we observed.

During our inspection we were told about the poor practice of one member of staff, when we spoke with the acting manager about this they addressed it immediately demonstrating to us that they would not tolerate poor practice.

We observed some caring interaction, for example one person told us they had a headache. Staff bringing round the tea asked them how they were feeling and asked them about other aches and pains and how they had slept. These were all issues they had raised with us as being a concern to them. The staff member knew what their concerns were and took steps to reassure them about when they would receive their next pain relief and was very kind and caring. Another person said, "The staff are marvellous."

We noted that relatives were treated with compassion when their family member passed away. We also saw that staff accompanied a person to hospital and spent sixteen hours with them due to their distress. Staff told us they would do this if they could not get a relative to attend. This was seen as a good and caring practice.

Another person was observed as becoming distressed Staff stopped what they were doing to talk to them, reassuring them by speaking softly, asking what was wrong and holding their hand. They then went to get them a cup of tea which they requested.

One staff member paid a person a compliment about how well they were caring for the 'baby.' The person responded positively to this.

One agency staff member was seen to be very kind and patiently help one person to have 'little sips' of their drink.

We were not assured that people always have their dignity upheld. We observed staff pulling people backwards in bucket chairs without any warning which must have been frightening for people. We also noted that when people were given snacks/ drinks there were not given side tables and people were not offered plates to put their snacks on. This meant that people were trying to balance items on their lap.

People were assisted into the dining room 50 minutes before the evening meal was due. This was not dignified and was potentially confusing for some people. The room had previously been locked and the dining experience lacked ambiance.

People's dignity was not always upheld. We noted in some areas of the home and in individual rooms some had a very strong smell of urine and body Odour in the room. We observed a staff member shouting to another could they have a tissue as a person's nose was running.

Clothes were named which was not always dignified. So for example a person's name went right across their slippers. And was visible for all to see.

The feedback we had on how staff encouraged people's independence and choices were also mixed. One person told us that they did not wish to be washed by a staff member of the opposite gender. They told us that this had been discussed with them and their relative and they had made their views clear. They said, "I've expressed my wishes. My [relative] came and they wrote it all down". Another person who appeared quite able told us "one thing they haven't done is ask me how I want to be cared for or how they can help me help myself."

Although we saw good practice it was not consistent throughout the home and we discussed this with the acting manager. What was lacking was direct observations of staff

Requires improvement

Is the service caring?

practice. People were consulted about their needs and care plans asked people their wishes, choices and preferences but the care we observed did not always reflect individualised care.

Requires improvement

Is the service responsive?

Our findings

Not everyone observed throughout the inspection were given sufficient opportunity to join in activities and activities were not always suited to individual's needs. We spoke with people about their experiences and observed activities. Some people were positive and told us about things that had taken place which they had enjoyed including a singer singing songs from the 1940's and a Christmas party and occasionally going out with staff in the grounds. One person told us how much they enjoyed staff company. We observed some people having their nails done and a music/singing session which people seemed to enjoy. Other people were not able to tell us what activities took place or what they enjoyed. Others commented on not enough to do and limited interaction for staff.

We noted that there was a planned activity each day, some were offered on a group basis and others one to one such as manicures. The activities co-ordinator said amongst the activities were monthly outside entertainers as well as cake baking, art and crafts and ball games. The activities coordinator was seen to be very caring and people responded well to her. Staff told us they helped activities to take place but more so in the afternoon when they were less busy. This was also a time when there were less staff on shift. The provider told us there were 25.5 hours a week which they felt was a generous allocation. The home could accommodate up to 55 people when full and people had varying degrees of cognitive impairment whilst other people had no mental impairment. We observed it was difficult for one staff member to provide sufficient stimulation for people based around their individual needs. The activity coordinator tried to vary what they offered but activities were restricted mainly to the day with reduced opportunities at the weekend and evening. Staff told us at these times there were family and friends visiting but there was an acknowledgment that not everyone had family and the home had no volunteers or befrienders to support people who did not have regular visitors. We also noted that although people joined in an activity for others they were sat all day without a great deal of interaction from staff unless it was to ask if they needed the toilet or wanted a drink.

The home did not have transport so people were restricted in getting out and had to wait until staff were available to assist them. The activities coordinator said they were going to set up a mobile shop. We noted there was equipment in the home and a budget for activities as well as some fundraising going on. However there was limited sensory materials for people to help with tactile stimulation. The activities co-ordinator told us although they recorded what people did through the day they did not record when people had not wished to participate or evaluate activities to see what had worked well or what had not to see if it was worth repeating.

It was not clear from the records we looked at whether there was a coherent approach to managing people's weight loss. We found records were kept for everyone in terms of what they ate and drank regardless of whether a nutritional or hydration risk had been identified. Staff told us everyone was being weighed monthly but when we looked at people's records we saw that some people had lost weight but were still being weighed monthly. There was some inconsistencies in people's records such as reporting the person was eating well whereas records showed us they were losing weight and, or variants in people's weight and height. People's nutritional needs were monitored but there were different records staff were using to record on. This included food and fluid records and where people were identified at risk an additional chart was used to record supplements, milky drinks and snacks. At the end of the end of shift records were entered on to the person's electronic record. The people identified at nutritional risk were receiving supplements but not being weighed weekly which is contradictory to what we were told should be happening.

Carers update daily records on care plans on a terminal in the carer's office. A paper file was used on the floor for each person to record personal care given and this was fed into the daily records. Other updates, such as changing care needs and risk assessments, for example any changes in mobility was completed by senior staff.

Initial assessments were carried out by a designated senior, or the manager or one of their two deputies. A senior member of staff would initially visit the person at their home/hospital etc. to make an initial assessment of the person's needs. Where possible the same senior member of staff would then carry out the initial detailed assessment on arrival.

The acting manager said families were encouraged to complete 'This is Me' which gave personal information

Requires improvement

Is the service responsive?

about the person, including family history, previous occupation and details of family. This could be used by staff to help them establish a relationship with the person and provide support tailored around their individual needs.

The home had devised a good system in which people were assigned a key worker who oversaw the persons care and this would be overseen by a senior. There was an ongoing review of people's developing needs and the service also tried to ensure that there was a formal review of each person's care plan by a Senior every 31 days. They used a traffic light system against people's names to indicate when care plans were coming up for review.

We reviewed five care plans and in summary found: Care plans accorded with information given to inspection team by staff and people themselves. There were brief notes in the care plan which gave a quick overview, but there was data behind this that can be easily accessed e.g. to inform staff how best to support individuals. We were easily able to pull up information e.g. incidence of accidents and details of the individual accidents. Care needs were written in the first person. And headings include mobility, finance, and 'daily life' using brief statements to describe 'current situation' and 'expected outcome' e.g. under, emotional support the 'current situation' statement is 'I am able to express myself when I want' and the 'expected outcome' is 'To continue to express myself when I want'. An 'actions' column (not visible until curser moved under the title.) this gave detailed information about how to provide support to the person, for example if they are feeling upset. It also included people's preferences and choices.

There were some inconsistency in records such as falls history and recording of weight. There was little evidence of participation in activities and no records seen showing that staff stay and chat with people, for example if a person is distressed, even when 'reassurance' was identified as part of the action to be taken to support people suffering from anxiety.

The home had a complaints procedure policy in place. Complaints were to be routed to manager or Director who said they would attempt to resolve them within 7 days. The policy signposted the complainant to other bodies if not satisfactorily resolved. There were three complaints recorded and these had been investigated sufficiently with outcomes recorded and what resolution/action had been taken.

Requires improvement

Is the service well-led?

Our findings

The home did not have a manager at the time of our inspection as the registered manager was off and the interim manager had left several weeks ago. The acting manager was supporting staff and managing the service. Staff spoken with said the home had improved and they found the acting manager approachable and willing to listen to their suggestions and ideas. Staffs view on the current staffing levels were positive as were some of the people we spoke with. However other people commented on the staffing levels suggesting there were not always enough staff who were familiar with their needs or who spent time with them outside of delivering personal care. Since the last comprehensive inspection in July 2015 there have been some changes to the service including the sudden departure of the interim manager and significant concerns over the safety of medication administration On the day of inspection we identified improvements required across each key line of enquiry but also identified some very good care being provided. We also noted some staff were working a lot of shifts which we felt could be detrimental to their well-being and the smooth running of the service. It is the employers responsibility to ensure that take into account relevant legislation like the working time directive and closely monitor staff hours and ensure the health and safety of its employees

There was adequate management cover and a staff member with seniority at all times available to support staff. However we were concerned that improvements made earlier in the year had not been maintained in each area. In July the service was rated as good but we now found it required improvement in all areas.

The acting manager was supported by other senior staff and said they had a mixture of care shifts and administrative time. They said they were supported by the provider and had clear lines of responsibility and accountability.

Some restrictions of information had been applied to protect confidential information and to give permissions to certain staff so information could be accessed on a need to know basis. All permanent staff could access people's electronic records but we found some information required was not available to us on the day of our inspection.

The acting manager also told us they had attended the first meeting of the PROSPER project which was a project arranged through the Local Authority and stands for promoting safer provision of care for elderly residents. It aims to reduce the number of hospital admissions primarily as a result of falls, pressure ulcers and, infections. It helps staff through support, training, and sharing good practice across the sector. Staff were attending from the home across both the day and night shift.

Some audits were being completed and this included falls audits. Other audits included dining/catering audits and medication audits. Cleaning audits were also being completed but some of the areas we had identified were not being picked up by the homes audits and they were not as thorough as they could be.

The acting manager said some staff training needed to be refreshed to ensure their knowledge was up to date. They said this was being addressed and some staff were enrolling on higher vocational courses in the new year. They were unable to tell us, how many staff already held a higher qualification or what skills they had because a skills audit had not been completed This would help determine clear roles and responsibilities within the home depending on staffs experience and expertise.

Staff, resident and relative meetings were held and some people were aware of this and participated in them. One person told us nothing changed as a result of the meetings. However we were encouraged by the regular introduction of these meetings which were chaired by a person using the service and facilitated by the activities co-ordinator. The chef told us they also attended as did other Heads of department. We saw meetings had agenda in place and surveys were also used to gauge people's experiences. An example of this was a food quality survey which meant they were listening to people and trying to improve people's experiences. A more general quality assurance survey was circulated annually, last produced in July 2015 and included feedback from people using the service and their families.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The premises were not suitably maintained or safe for its intended purpose. This was a breach in regulation 12.

This section is primarily information for the provider

Enforcement actions

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