Abbey Healthcare (Kendal) Limited

Heron Hill Care Home

Inspection report

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Ratings

Overall rating for this service	**Good**
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?	**Good**

Overall summary

This unannounced inspection of Heron Hill Care Home took place over three days on 17, 20 and 21 July 2015. During our previous inspection visits on 21 and 22 October 2014 and 11 May 2015 we found the service was not meeting all the regulations.

This was because at our inspection on 21 and 22 October 2014 there was not verifiable evidence that all staff in the home had received induction training, appropriate training for their roles or regular supervision and appraisal to monitor their performance. People living there could not be sure the staff caring for them had received appropriate training and supervision to meet their needs.

We also found at that inspection that people were not being protected against the risk of unsafe care because the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness. We issued requirement notices to the provider that required them to make improvements in relation to staff training and supervision and the effective monitoring of records and

Summary of findings

service provision. The registered provider wrote to us and gave us an action plan saying how and by what date they would make the required improvements. They also told us how they would monitor this.

We also carried out an inspection 11 May 2015 following concerns raised by agencies and individuals regarding low staffing levels within the home. At this inspection we found that the registered provider did not have effective systems to ensure they consistently deployed sufficient numbers of suitably qualified and skilled staff to make sure that people's care and treatment needs were always met. We issued a requirement notice that required them to make improvements in relation to this.

At this inspection17, 20 and 21 July 2015 we found that the registered provider had made the improvements needed to meet the requirement notices from the previous visits. However at this inspection we found that there was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities Regulations) 2014 regarding the proper and safe management of medicines. We found that medicines were being not stored safely during medicines rounds and administration was not recorded correctly. We found that care plans for the management of medicines and creams did not contain sufficient detail to make sure that residents received appropriate care.

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

Heron Hill Care Home provides accommodation and nursing care for up to 86 people. The home is over three floors and has four separate units and each unit had separate dining and communal areas. All bedrooms in the home are for single occupancy and have ensuite facilities. The service provides support to adults who have a physical disability, mental health needs, behaviour support needs, dementia and complex nursing needs. During the period of the inspection there were 67 people living there.

The service had 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.

We spoke with people in their own rooms and those who were sitting in the communal areas and were told by people that they felt the standard of care was satisfactory. The home had moving and handling equipment and aids to meet people's mobility needs and to promote their independence. The home was being maintained and we found that all areas were clean and free from unpleasant odours.

We found that there was sufficient staff on duty to provide support to people to meet individual's personal care needs. Staff had received training relevant to their roles and were supported and supervised by the registered manager and the care manager. The home had effective systems when new staff were recruited and all staff had appropriate security checks before starting work. The staff we spoke with were aware of their responsibilities to protect people from harm or abuse.

The service had worked well with health care professionals and external agencies such as social services and mental health services and the Care Home Education and Support Service to provide appropriate care to meet people's different physical, psychological and emotional needs.

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves.

People were able to see their friends and families as they wanted and go out into the community with support. There were no restrictions on when people could visit the home. All the visitors we spoke with told us that staff were "friendly".

People had a choice of meals and drinks. People who needed support to eat and drink received this in a supportive and respectful manner. We saw that people were supported to maintain their independence and control over their lives as much as possible.

There were quality monitoring systems in place and being used to assess and review the quality of the services provided.

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 service was not safe.

People were not being protected against the risks associated with the use and management of medicines. Care workers did not have clear guidance to follow to ensure that residents received correct treatment to protect their skin.

A dependency tool was being used to monitor staffing. Attention needed to be paid to the gender mix of staff in line with risk assessments.

Staff had been recruited safely with all relevant security checks in place.

Staff we spoke with in the home knew how to recognise possible abusive situations and how it should be reported.

Is the service effective?

Good

The service was effective.

Nursing and care staff working in the home had received training and supervision relevant to their roles.

The Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards were followed when decisions were made on their behalf.

People had a choice of meals, drinks and snacks.

Is the service caring?

Good

This service was caring.

We saw that the staff treated people in a kind and respectful way and that their independence, privacy and dignity was promoted.

The staff took time to speak with people and gave them the time to express themselves.

Care plans contained information about people's care and treatment wishes should their condition deteriorate.

Is the service responsive?

Good

The service was responsive.

Support was being provided to people to follow their own interests and faiths and to maintain relationships with friends and relatives and local community contact.

Care plans and records showed that people were being seen by appropriate professionals to meet their physical and mental health needs

There was a system in place to receive and handle complaints or concerns raised.

Summary of findings

Is the service well-led?

Good

The service was well led.

Processes were in place to monitor the quality of the service and action had been taken when it was identified that improvements were required.

Staff felt the registered manager was approachable and they could raise any concerns or questions they had about the service with him.

People who lived in the home and their visitors were asked for their views of the service.

Heron Hill 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.'

We visited the home on 17, 20 and 21 July 2015. Our inspection was unannounced and the inspection team consisted of two Adult Social Care (ASC) Inspectors, an expert by experience (ExE) and a pharmacist inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with 15 people who lived in the home, seven relatives/visitors, five nurses, seven care staff, four ancillary staff, including domestic and maintenance staff and activities staff. We spoke with two visiting health care professionals, the registered manager, the regional manager, the deputy manager, the unit managers and the newly appointed activities and training manager. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We spoke with people in communal areas and in private in their bedrooms. We looked in detail at the care plans and records for 13 people and tracked their care. We looked at records that related to how the home was being managed.

We looked at records, medicines and care plans relating to the use of medicines in detail for seven residents on a unit that cared for people living with dementia. We observed medicines being handled and discussed medicines staff.

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 with us. It is useful to help us assess the quality of interactions between people who use a service and the staff who support them.

Before our inspection we reviewed the information we held about the service, including information we had asked the registered provider to send to us. We also contacted local commissioners of the services provided by Heron Hill to obtain their views of the home. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals and applications the manager had made under deprivation of liberty safeguards. We looked at information sent to us by health care professionals involved in providing care and support to the people living there to get their views on service provision.

Before the inspection the registered manager completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

We spoke with people who lived at Heron Hill about their life in the home. We were told by one person, "I feel safe in here and I can trust the staff, I think that we have the same staff all the time". We were also told "There are sufficient staff; I have never had to use my call bell. My room is very comfortable and I spend a lot of time in it". Another person told us, "The staff on the day shift are OK, the night shift are OK but they have too much to do really". Another commented, "I don't think there are enough staff at times".

A relative told us "I feel [relative] is safe here, it's a relief as [relative] is happy here and looked after". Another commented" "I don't think there are enough staff at times". Relatives we spoke with told us, "The staffing levels are sometimes good and sometimes there is the right amount of support for my [relative], the staff support me and they tell me how [relative] is doing". We were also told "The home is busier than it was and the staff look tired".

At our focused inspection on 11 May 2015 we had found that staff levels and skill mixes on some units were still not consistent and stable. At this inspection we found that steps had been taken to address and improve this in line with the action plan the registered manager had previously sent us. A shift monitoring system had been put in place and this was based upon a dependency tool. The tool classified eight levels of dependency based on needs that were used to calculate the dependency category and the number of people in each, the overall hours of care required, the total number of registered nurses and care assistant hours needed to provide the level of care required. We could see the practical results in the increased numbers of staff being deployed on the different units in line with their occupancy and the dependency/care needs of the people living there.

We discussed with the registered manager the value of making it priority to have a male member of staff on all shifts on Baden Powell unit. On a shift with all female staff all the men living on the unit had been risk assessed at needing two female carers to assist with personal care but on a shift with a male carer only seven needed this. We asked staff about this and they told us, "That's why we struggle in a morning". We raised this with the registered manager. They agreed that it would be a better use of staffing resources and better support some people's assessed needs and risks. They addressed this during our inspection.

We also asked about the systems in place for flexibility around summoning additional staff in emergency situations on Baden Powell unit. The registered manager told us that arrangements were in place to use 'walkie talkies' to request assistance. Staff we spoke with told us they were not aware of this and there was no formal protocol in place. The manager addressed this during the period of our inspection and a protocol and communication equipment was put in place for responding to incidents requiring assistance.

We also noted that incident reporting by staff was not covering all incidents, such as one's they considered low level. This was addressed with staff during the period of our inspection. We did observe an incident of physical aggression on Baden Powell unit. We found that the three staff on duty managed this well and completed behavioural monitoring and incident reporting records.

We observed the administration of oral medicines by nurses and this was done with kindness and patience. However, we saw that medicines were not kept safely during the medicines round and residents were able to have access to them. We also saw that one person didn't receive their tablet at the correct time that was essential to keep them well. During the medicines round we saw that records for the administration of medicines for five people who lived there were signed all at once and not at the time that medicines were administered. This increased the risk of harm from recording errors.

There were not always sufficient quantities of medicines in stock to ensure the safety of residents and to meet their needs. Three people had a medicine that was not available to them in the two weeks before the inspection. We saw evidence that staff had ordered the medicines but this was not done in a timely manner to ensure a continuous supply in the home.

We found that 'when required' protocols relating to the management of medicines were poor and this could result in residents receiving incorrect or inappropriate treatment.

Requires improvement

Is the service safe?

For example, a 'when required' protocol and care plan for the management of "difficult behaviour" using a sedative did not identify other management options to employ before resorting to sedation.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate arrangements were not in place to ensure the proper and safe management of medicines within the home.

We found that the task of administration of skin softening and barrier (skin protecting) creams was delegated to care workers who completed separate administration records specifically for creams. We were told that a nurse also signed the main medicines administration record, that listed all medicines prescribed for residents. This was to show that they had checked that the care workers had performed the task. However, we found that the main administration record did not list all of the creams prescribed for residents so the nurse may not be aware which creams needed checking.

Some creams that were we found in people's rooms did not have associated medicine administration records for care workers to sign so we did not know if they were being used or not. Some creams did not have any labels attached to them so it was not possible to tell if they were prescribed for the person in whose rooms they were found, or if they were being applied correctly in accordance with prescribed instructions. Care plans for the use of the creams did not always identify the creams to use or instructions for their use in a person's treatment. This meant that care workers did not have clear guidance to follow to ensure that residents received correct treatment to protect their skin.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not a clear administration plan and record covering the use of the creams in a person's treatment.

We found that systems were in place to make sure people living there were protected from abuse and avoidable harm. Staff told us they had received training in safeguarding adults. The nursing and care staff we spoke with could tell us of what may constitute abuse and how to report it to managers for referral to the local authority. The registered manager has notified CQC of any referrals to the local authority made under safeguarding procedures.

The registered provider was continuing to actively recruit to the permanent staffing establishment and to try to develop a 'bank' of staff to cover sickness and holidays. During this inspection we looked at ten recruitment records for staff employed since our last inspection. The registered provider for the service had systems in place to ensure staff were only employed if they were suitable to work in a care environment. We saw that all the checks and information required by law had been obtained before the staff were offered employment in the home. Checks were made to ensure that registered nurses working in the home were registered with their professional body and fit to practice.

Good

Is the service effective?

Our findings

We were told by a person living at the home "I am happy with the care I receive here, I think that the standard of the staff is good". We were told "The food is good with a choice of meals everyday". Another person told us "The food is quite good, I could have my meals in my room if I was ill". We were told by a relative that "[Relative] really enjoys their food, there's a good choice".

However one relative we spoke with told us they felt "There is not a lot of choice of food". A person who lived there told us "The food is just plonked in front of you, if you eat it then you eat it if not it is just taken away".

At our last inspection on 21 and 22 October 2014 and we found that people living at Heron Hill could not be sure the staff caring for them had received appropriate training and supervision to help make sure they had the skills and knowledge to meet their needs. At this inspection 17, 20 and 21 July we found that steps had been taken to address this. A new training and activities manager post had been created so that there was one person taking overall charge of and coordinating the training provision and the activities programmes within the home. We spoke with them about their new role and the training programmes in place and being planned. Part of their role would be to make sure practical training and competence observations took place in areas such as moving and handling.

A training analysis or audit had been done to identify what training was required and by whom. A training plan had been developed on the basis of this to make sure the identified training was put in place and the timescales stated for achieving this and who was responsible for its completion.

We could see that following the training audit all staff had fire training updates

The training plan identified priority areas such as updating staff and giving training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty safeguards(DoLS). We found from training records and from what nursing staff told us that they had been able to attend training relevant to their roles. This included recent training on the use of syringe drivers [a syringe driver is a pump that delivers a measured dose of a medication] for the provision of effective palliative care. Some had also done courses to maintain clinical skills such as taking bloods, diabetes and blood glucose monitoring, feeding people using feeding tubes in the stomach, tissue viability and emergency first aid at work.

We saw that the Care Home Education and Support Service (CHESS) team was providing training for staff where they would be covering dementia awareness, person centred care, understanding behaviours, meaningful activities and nutrition. The CHESS mental health education programme is a rolling education al programme that runs over 11 weeks. The CHESS team work 'alongside' care home staff to back up learning with practical support. Some new staff were starting this in September 2015 and most existing staff had done this.

Staff we spoke with confirmed they had regular supervision meetings with a senior staff member to discuss their practice and any areas for development. Supervision is a meeting between staff and their manager where issues relating to work can be discussed. This helped to ensure that nursing and care staff had appropriate support to carry out their roles safely and effectively and have their performance monitored.

We made observations of the meal times on the nursing unit and on one where people were living with dementia. We saw that there was a choice of food at each meal. We observed that staff assisted people with their meals if they needed this and helped them cut up food to make it easier for people to eat their meals independently. We saw that people had plate guards to help them with eating independently. We observed that people were not being rushed with their meals and saw staff telling them to take their time and also encouraged them to chew their food properly. Fluids were given before the meal and people had a choice. Some had milkshake or juice and others hot drinks. We saw that nutritional records were completed following the meal.

All of the care plans we looked at contained a nutritional assessment and a regular check on people's weight for changes. We saw that if someone found it difficult to eat or swallow advice was sought from the dietician or the speech and language therapist (SALT) and a plan developed to support them.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA)

Good

Is the service effective?

and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The staff we spoke with knew why a Deprivation of Liberty Safeguard would be required for a person and who was subject to this on their unit. All staff we spoke with demonstrated an awareness of the MCA code of practice and the processes involved.

The registered manager knew when a Deprivation of Liberty Safeguard was required to protect an individual's rights. We saw that the registered manager had raised potential restrictions with the managing authority to make sure they were acting in line with the legislation.

Some people who lived at the home were not able to easily make important decisions about their care and treatment due to living with dementia or mental health needs. We looked at care plans on the units to see how decisions had been made around their treatment choices and specifically 'do not attempt cardio pulmonary resuscitation' (DNACPR).

A multi-disciplinary approach was taken to decisions being made in people's best interests and there was information about who held a Power of Attorney for someone. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or also care and welfare needs. We could see that decisions had been made with involvement of doctors, families and care staff looking after them and that records were kept of the processes involved.

We saw that people who had capacity to make decisions about their care and treatment had been supported to do so. We saw that people had the opportunity to make decisions about future care, treatment and their wishes should their health needs change radically and this was recorded in their plans. Some people had personalised plans of care from their GPs so people had been given the opportunity to let the healthcare team know how they wanted to be looked after in future and in an emergency.

Good

Is the service caring?

Our findings

We spoke with people living in the home about how they were cared for and how staff supported them to live as they wanted. People we spoke with told us “The staff are kind to me they treat me with dignity and respect when they shower me” and “On the whole I am listened too, I can get up and go to bed when I wish”. Other people told us “They’re [staff] caring but I would prefer a female carer all the time, I go to bed when I like. When they help me wash I am treated with dignity and respect and the staff listen to me. They are very good”. We were also told us, “They [staff] know me well”.

We spoke to relatives about the care people received and the attitude and approach of staff. One relative told us “I come in regularly to see [relative]. I have found it a good place; they [staff] do a hard job but are always pleasant from what I have seen. It’s important that they are cheerful and kind, I feel reassured by that”. Another spouse told us, “They [staff] are trying to keep [relative] independent and help them join in”. We received other comments from relatives including “We are over the moon with the care and the staff are brilliant” and “[Relative] is a lot happier in the home”. Another relative told us “I have no worries, the staff are so good. It’s surprised me how understanding staff have been and caring and helpful”. We were also told by a family member of one person living there “Everyone [staff] is very helpful and pleasant”. Another told us “The staff are caring”.

We saw that people’s privacy was being respected. We saw that staff protected people's privacy by knocking on doors to private rooms before entering. We saw that staff provided people with equipment to aid their mobility when they were needed. We saw that staff maintained people’s personal dignity when assisting them with equipment and with transferring people from a wheelchair to an easy chair. All bedrooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to.

We found that a range of information and leaflets was available for people in the home and their relatives to inform and support their choices. This included information about the providers, the services offered, about support agencies such as Age Concern and financial help and advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want or need this.

As we spent time in different communal areas of the home we saw that the nursing and care staff engaged positively with people and we saw people enjoyed talking with the staff. Activities and conversations were going on in the lounges and it was a convivial atmosphere. Throughout our inspection we saw that the staff gave people the time they needed to communicate their wishes.

The registered manager had procedures in place to support people at the end of life and equipment and end of life medicines were available when needed. Recently nursing staff had received training on the use of equipment that was used to provide symptom control so people requiring palliative medicines could receive them quickly and by the most effective route.

Good

Is the service responsive?

Our findings

People who were able to comment said that staff were available to help and support them when they wanted them. People that we spoke with told us that daily routines in the home were flexible, such as when they got up and went to bed, where they had their chosen meals and taking part in organised activities. All the people spoken with said that they could come or have visitors at any "reasonable" time. One person told us "I have been into painting classes and have done a butterfly". We saw people's art work and saw that a lot of time and effort had been put into this work and people told us they felt a sense of achievement from doing this art work.

We spoke with visiting relatives and they gave us their views on how the service planned and responded to people's needs in a person centred way. There was a range of views expressed reflecting people's different experiences of service provision and person centred care. One relative told us "The staff respond to both our needs my [relative's] condition has got worse and they have been poorly, at present they are on antibiotics. We can come and visit at any time". Another told us, "The standard of care is good and we are listened to about their care". The spouse of another person living there told us that "The staff are knowledgeable about [relative's] condition and they usually get the care and support they want" and also that "They keep me up to date with [relative's] condition".

One relative told us "It's not bad but there is still room for improvement" and also "The standard of care can vary from time to time". The relative of one person told us that "The standard of care is reasonable but the personal care of my [relative is not always so good".

One person living there told us "If I had any complaints to make I would go to the manager, but I have not had to complain so far". Other people who lived there and relatives told us they knew they could make a complaint about the service if they felt they needed to and that there was a complaints procedure displayed throughout the home and in bedrooms.

We saw that complaints that had been made were logged and the action taken in response to complaints had been recorded and had been dealt with by the registered manager. The records available indicated that the registered provider and registered manager had responded when a complaint had been made to them. There was a copy of the last complaint's audit on the notice board in the main foyer.

People's care records showed that their individual needs had been assessed when they came to live there. The information gathered was used to develop individual care plans. We saw information had been added to plans of care as they were developed and as the persons preferences and wishes became known. People's care plans included risk assessments for pressure care, falls, moving and handling and mobility and nutrition.

One person living there told us "I do not know if I have a care plan, but I have seen my own doctor once". We found that the registered manager had been sending out invitations to people's families to ask them if they would like to help with care planning for their relatives. This was to try and increase people and their families involvement in the care provided at the home.

We found people had been assessed to determine whether they were at risk of malnutrition. We saw that care plans reflected specific nutritional needs and where there were risks from choking. We could see that the Speech and Language Therapist (SALT) had been asked to assess people's choking risks and care plans had been developed following their guidance, such as using fortified drinks to boost nutrition and thickening agents to help reduce choking risks.

Records indicated that reviews had been carried out on people's assessed needs and the associated risks. We looked at care plans for people with more complex healthcare needs and saw that these had been regularly reviewed so that people continued to receive appropriate care.

We spoke with visiting health care professionals who were involved in supporting people using the service. We spoke with an occupational therapist (OT) who worked with the CHESS team as part of its outreach service supporting care homes. We looked at care plans and observed the joint working between unit staff and other health care professionals and how they were working together to plan a programme to help a person with their mental health issues. This work had been on going and from the

Good

Is the service responsive?

discussion we had, the care records and speaking with the person involved we could see that the joint working had been successful in improving mental wellbeing for that person and improving their quality of life.

We spoke with unit managers who told us about their weekly meetings with the Kendal Care Home Pilot Project. This took place on Mondays where medications could be reviewed and any palliative care needs discussed. The healthcare professionals we spoke with told us that the unit managers and staff worked well with them on this. As a result the number of people living there who had needed to go to hospital for treatment had fallen as they could receive appropriate care in the home.

A relative told us, "There is not enough going on to occupy my [relative's] mind, but everyone is very helpful". We saw that there was a programme of organised activities within the home and could see what had been provided from records and talking with people. A staff member we talked with told us "There has been a shake up with the activities lately". We saw that that the registered provider had recognised that the activities provision at Heron Hill had needed to be improved to give people greater choice and opportunities for individual activities. The numbers of activities coordinators had increased and Heron Hill had access to more activities staff from their 'sister' home , close by, so there was one available for each unit. Recruitment was going on to attract people to work as activities coordinators at Heron Hill.

This had helped to provide more opportunity for group and individual activities and recruitment to this post was continuing. On Baden Powell unit staff told us they were having more input from activities staff coming onto the unit more often. They had supported some people to go out for a drink in the evenings. We were told by staff "It's great for them to be able to go out more".

We saw that people had the opportunity to follow their own faiths and beliefs and see their own priests and clergy. People could also attend multi denominational services in the home if they wanted.

Good

Is the service well-led?

Our findings

We spoke to people living at Heron Hill and their visitors/ relatives about how the home was run for them and their involvement in this. One person told us, "My son has been sent a survey. I am not sure if we have meetings but I have not been asked my views on the home directly". Another told us "The management could be better" and another said "I'm not sure who the manager is but the staff are all approachable".

A relative who was visiting told us "It is a well managed home and we are pleased that [relative] is in here". Another relative told us "I'm not sure who the manager is but the staff are all approachable". We were also told "The home is not too badly managed".

The service had a registered manager in post as required by their registration with the CQC. The registered manager had been in post since December 2013.

At our last inspection on 21 and 22 October 2014 and we found that the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness. At our last inspection the implementation of the quality assurance systems had not been consistently effective and records had not always been kept up to date. At this inspection we saw that were clear organisational action plans in place for the improvements required from the last inspection. These showed how audit processes were in place and being used for monitoring the safety and effectiveness of the service provision.

The registered provider had a clear system in place for the registered manager to undertake quality checks across all the different suites and departments in the service. The information was collated in a monthly 'Home Manager's Audit' and the information reported back to the registered provider's quality monitoring department. We found that there was a measurable and verifiable system being consistently applied since our last inspection. The audits covered all aspects of the service including record keeping, training, activities provision, staffing.

We spoke with the unit managers about how quality was monitored on the units. They told us about the weekly audits they did to gather information to pass to the manager for their overall analysis of effectiveness. These 'key performance indicators' (KPI's) covered people's dependency level scores, skin condition, any infections, accidents, incidents, visits from other health and social care professionals and staff supervisions completed. Nursing staff we spoke with told us they had found that this had improved the overall monitoring on the units.

We found that there were regular heads of department meetings being held to promote effective communication and planning across the home and check that action plans were being followed. Staff told us that they had staff and unit meetings to discuss matters and promote communication about what was going on and we saw records of these. We could see from records that meetings were held for people living there and their relatives to attend if they wanted to. This was to allow people to discuss what they wanted in their home and any issues they had with life there.

We looked at the records of accidents and incidents that had occurred in the home on the units. We did this to check if action had been taken promptly to analyse any incidents and make changes if needed. We saw that incidents had been recorded and followed up formally with appropriate agencies or individuals where needed. We saw that incident analysis was part of the manager's audit and that a record kept of what action had been taken to help prevent a reoccurrence.

We saw that regular audits had been done on care plans, weights and care records, wound management, medication records, the premises and environment and staff training and supervision. Maintenance and equipment checks were being done regularly by staff and records had been kept and we could see that any repairs or faults had been highlighted and acted upon. Staff sickness and absences were being monitored and followed up using the organisations procedures to support people and identify reasons for absences. We also saw that exit interviews were held with staff that were leaving to help identify their reasons to inform recruitment and retention.

Staff told us that the registered manager and unit managers were "always available" and also "Will listen to what we have to say and will do their best to get what we need".

We spoke with the manager of the home and the regional manager during the inspection. Both were responsive to any issues raised and proposed courses of action and formal action plans to manage them. The plans and

Good

Is the service well-led?

actions taken over the period of the inspection indicated to us that the issues were being taken seriously and steps were being taken to address them. Both demonstrated a clear idea of how the service to could maintain improvements and develop.

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
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not being protected against the risks associated with the use and management of medicines. Medicines were not stored safely during medicines rounds, and administration was not being recorded correctly. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: There was not a clear administration plan and record covering the use of the creams in people's individual treatment so care workers did not have clear guidance to follow to ensure that residents received correct treatment to protect their skin. Regulation 9 (1)