Care UK Community Partnerships Ltd

Collingwood Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Collingwood Court is operated by Care UK Community Partnerships Ltd. It is a large three storey residential care home situated in North Shields, North Tyneside. The service currently provides accommodation, care and support to 55 older people, most of whom have physical and/or mental health conditions.

This inspection took place on 9, 10 and 11 March 2016 and was unannounced. We last inspected this service in March 2014, at which time we found them to be compliant against all of the regulations that we inspected.

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.

People told us they felt safe living at Collingwood Court with support from the staff. There was a safeguarding policy in place and staff understood their responsibilities with regards to protecting people from harm or improper treatment. There were mixed feelings amongst people and staff as to whether there were enough staff employed at the service. We discussed this with the registered manager who told us she was in the process of recruiting more staff; however she felt the care staff had worked hard as a team to ensure the shortages did not affect people's care.

Policies, procedures and systems were in place to provide support to the staff. We found that staff were not using the systems effectively enough to enable them to provide safe, high quality care. Record keeping required improvement; in particular care plans were basic and brief. In some cases, whole sections of the care plans we examined were blank.

Personal emergency evacuation plans were in place and checks on the safety of the home were routinely carried out by maintenance staff as well as by external professionals where necessary.

Medicines were not always managed in line with safe working practices. We found concern around the storage and disposal of surplus medicines. We observed medicines being administered safely and hygienically and medicine administration records were well maintained and accurate.

Accidents and incidents were recorded manually and passed to the deputy manager to input onto the electronic care records system. We found there was a delay in this process which had led to two people not receiving medical attention and further action to monitor and refer people to other appropriate healthcare professionals had not taken place. We made safeguarding alerts to the local authority regarding several incidents which had taken place recently.

Resident/Relative meetings and annual surveys were used to gather feedback and opinions from people

about the home and the service they received.

Evidence showed the registered manager and staff did not have a thorough understanding of the Mental Capacity Act (MCA) and their own responsibilities. Most people living at the home lacked mental capacity and the registered manager had applied to the local authority for deprivation of liberty authorisations. However decisions which were made in people's best interests had not been carried out in line with the MCA principals.

We saw that people were supported by staff to maintain a well-balanced, healthy diet. We found staff received an induction and were trained; however formal staff supervisions and appraisals were overdue.

People were respected and their privacy and dignity was maintained. Staff displayed kind and caring attitudes and treated people as individuals. Staff gave people choices and encouraged them to make small decisions about their daily life.

We observed people participated in a wide range of activities. The service supported people to maintain links by welcoming family and friends into the home. People and their relatives told us they knew how to complain and would feel confident to do so if necessary.

Staff told us they worked well as a team. They felt supported by the registered manager whom one staff member described as "supportive and approachable".

The registered manager held records which showed the monitoring of quality and safety of the service through audits. However we found that several high risk issues which had been identified by the registered manager nine months ago were still outstanding at the time of our inspection.

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

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 always safe.

Safeguarding procedures were in place however, due to a delay in recording incidents, we found some people had not been safeguarded from further harm.

Risk assessments were basic and brief. They were not always updated following an incident.

Medicines were not always stored safely. However the administration of medicines and record keeping was appropriate.

The premises were well maintained and safety checks were carried out as necessary.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained however formal supervision was overdue.

The registered manager and staff did not have a thorough understanding of the Mental Capacity Act 2005 (MCA).

People were supported by staff to maintain a well-balanced diet. Staff gave people choices and respected them.

General healthcare needs were met.

Is the service caring?

Good

The service was caring.

People were cared for by staff who displayed kind and considerate attitudes.

Staff recognised people's diverse needs and catered for them appropriately.

People were treated with dignity and respect and their privacy

was maintained.

Staff dealt sensitively with relatives who were recently bereaved.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not make effective use of the recording systems in place.

Care needs assessments tools were used but not thoroughly translated into person-centred care plans.

Regular reviews took place but weren't thoroughly recorded in a timely manner.

People enjoyed a wide range of activities. People knew how to complain and felt confident to do so.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Record keeping was poor and lacked written evidence regarding the care and support people received.

Systems in place to monitor the quality and safety of the service were not effective enough to identify the issues we raised during the inspection.

Previously identified issues from an internal audit were not addressed in a timely manner.

Staff told us they felt supported by the management and there were staff recognition schemes in place to motivate staff.

Collingwood Court

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 9, 10 and 11 March 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert-by-experience. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection and have specialist knowledge in a certain area. The specialist advisor on this team had a background of working with older people with mental health related conditions and was a qualified nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about Collingwood Court including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

In addition, we contacted North Tyneside Council's contract monitoring team and safeguarding adults team, to obtain their feedback about the service. Healthwatch North Tyneside had recently completed their own report and shared this with the lead inspector. We also asked the provider to complete a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information informed our planning of the inspection.

During our inspection we spoke with 27 people who lived at Collingwood Court. We spoke with 12 members of staff including the registered manager, the deputy manager, senior care workers, care workers, domestic and maintenance staff, who were all on duty during the inspection. We also spoke with seven relatives of people who used the service, who were visiting at the time. We spoke with four external healthcare professionals who visited the home during our inspection. A representative from the provider also attended

part of the inspection and we were able to talk with them about leadership. We spent time observing care delivery at various times throughout the day, including the lunchtime experience in all three dining rooms and we observed people engaging with activities. We carried out some of our observations using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed 16 electronic care records in depth. We reviewed other elements of people's care, including inspecting paper care records, generic risk assessments and medicine administration records.

We looked at five staff files, including a mix of staff who carried out care and non-care related roles. Additionally, we examined a range of other management records related to the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

Electronic records of accidents and incidents were not found to be up to date. Due to this, we could only review these records up to the end of January 2016. These records contained basic details; name of the person, the date and time of the incident and a short sentence about the nature of the injury. For example, "(Person) was found on the floor in front of his bed". And "(Person) was found on the floor in her room". There were no thorough details recorded about the circumstances, the injuries, any action taken by staff, further medical intervention or action taken by the registered manager to prevent repeat events.

The service used a FRASE (Falls Risk Assessment Score for the Elderly) care planning tool to record information about falls risks. However in records we examined we did not find evidence to suggest these were updated and reviewed after each fall. One person had fallen seven times in the last five months and their current FRASE score was recorded as medium. The score was documented within the moving and handling care plan and there was no indication of an update or review. We spoke to the registered manager about this example and she told us that no action had yet been taken to address this. We asked the manager to contact this person's GP for a check-up and a possible referral to the falls clinic which she did immediately.

We saw generic risk assessments were in place in people's paper care records for hazards such as choking and accessing the community, however some risks to individual needs were briefly recorded in the electronic care needs assessments. In the care plans we examined we did not find these to be thorough or up to date. Some care plans contained basic notes with regards to preventative measures and instructions for staff to follow in the event of an incident. There was not a separate risk assessment document.

We looked at the system in place to manage medicines. We found appropriate arrangements for the safe handling of medicines were not always in place. During our observation in a treatment room, we saw a cupboard contained surplus medicine stocks was not locked. We also saw medicines which were waiting to be returned to the pharmacy for disposal were stacked on a bench in named envelopes. All other medicine was stored and locked away appropriately. We discussed the procedure for self –administration with a senior member of staff. This is a procedure which encourages a person to manage their own medicine if it is safe to do so. The response we were given did not meet with the providers policy for self-administration of medicines. We could not find any entries which related to self-administration of medicines in the care records we examined. We discussed this with the registered manager who confirmed the staff had not followed the providers own policy. We observed that this was rectified by the end of the day. We observed a senior member of care staff administer medication to people. We saw this was handled safely and hygienically. Medicine administration records (MARs) were completed appropriately.

We found the care records we examined did not contain information which related to prescribed medicine needs. For example, one entry which related to food and drink stated a person had diabetes which was controlled by tablets; however there was no medication care plan completed. Another person with diabetes had a blank medical and social history record.

This was a breach of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

Policies, procedures and best practice guidance were in place to safeguard people from abuse and improper treatment. We reviewed the records which related to incidents of a safeguarding nature. We found that the registered manager had implemented the local authority's safeguarding procedure and had also notified the Care Quality Commission when necessary. We discussed some recent incidents with the registered manager which had not yet been recorded. We were told that the deputy manager was in the process of inputting this information but there was a six week backlog due to the lack of administrative support. We alerted the local authority to our concerns of a safeguarding nature during the inspection.

People, relatives and staff told us they would not hesitate to report any concerns they had about safety to the registered manager. Everyone we spoke with said they were happy to approach her and discuss anything.

The registered manager had ensured personal emergency evacuation plans were devised. We saw that these were stored in a central file kept in the reception area. We did not find copies of these documents in the care records we examined.

The registered manager told us she was in the process of recruiting two care workers, one senior care worker and an administrator. One member of staff told us the shortage of staff had led to some day shift staff also covering night shifts. Another told us that due to a shortage of staff they had previously been left on a floor with 19 residents to look after while their colleague had a break. During the inspection, we observed short periods of time when people were left unsupervised, however during this time there were no incidents or no concerns raised. The registered manager told us there had been sickness leave and also inevitable annual leave; however she felt the care staff had worked as a team to ensure the service was suitably staffed and believed there were no concerns around staffing levels. Three other members of care staff we spoke with also had no concerns about staffing levels.

The service used CAPE (Clifton Assessment procedures for the Elderly), a nationally recognised tool for determining dependency levels. The results are based on people's needs and takes into consideration physical and mental health. The registered manager used her experience and knowledge to determine when people's needs changed to reassess staffing levels using CAPE. Throughout the day, care staff were deployed to other floors if their colleagues required support.

Staff recruitment records were found to be robust. There was evidence of an application and interview process. Suitable referees had been sought and an enhanced check had been carried out with the DBS. The Disclosure and Barring Service (DBS) check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are to be employed.

The premises were clean, comfortable and well maintained. We observed and spoke with domestic staff who were on duty during our inspection. Redecoration had taken place and new carpets had been laid in some areas. During our observations of the building we did find an area with a malodour, however the registered manager arranged for the carpet to be cleaned the following day. There were maintenance staff in post and we observed that they attended to minor repairs and safety checks around the home. We reviewed the records related to the safety of the premises, such as gas and electrical testing and fire safety equipment. These were found to be up to date and carried out by external professional contractors where necessary.

Requires Improvement

Is the service effective?

Our findings

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

We checked whether the provider was working within the principles of the MCA. Care records showed, and the registered manager confirmed that most people living at the home were subject to a DoLS. We reviewed the records regarding the application to the local authority and outcomes of these decisions. The manager had also notified the Care Quality Commission of these. However we did not find evidence of 'best interest' decisions being made for people who lacked mental capacity. People who lack mental capacity may still have the ability to consent to some aspects of their care and treatment. People should be included in the best interest decision making process along with their supporters. We discussed this with the registered manager who confirmed 'best interest' decisions had not been routinely considered or recorded in line with the MCA.

The electronic care records did not contain evidence which showed that people had consented to the care and treatment planned for them. Some paper records were kept to support the electronic system, these included copies of legal documents like 'Do Not Attempt Resuscitation' (DNAR) decisions. Forms which related to people consenting to their care and treatment were left blank. 'Lasting Power of Attorney' (LPA) decisions were recorded but they were not backed up with a copy of the legal document. A lasting power of attorney (LPA) is a legal document that lets you appoint people to help you make decisions or to make decisions on your behalf. We discussed this with the registered manager who told us she would contact the person's relative and request a copy.

This was a breach of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11. Need for consent.

Training records showed that in the past staff had completed an induction programme achieving the national minimum standards for adult social care. More recently, newer staff had undertaken the 'care certificate'. The care certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. The training records also showed that regular training was carried out to ensure staff have the necessary skills and knowledge to carry out their role. For example we saw certificates of achievement in safeguarding vulnerable adults, moving and handling, dementia and delirium training. A member of staff told us, "There is plenty of training available".

Supervision sessions were recorded and kept within staff personnel files. Of the five staff files we reviewed,

three included supervision documentation. These covered objectives, behaviours, development areas, actions and general comments. We noted that one record included shared learning from an incident within another home. We also noted areas for discussion included improvements which were being implemented throughout the home. Information we received from the registered manager showed some staff were overdue a supervision session and appraisals had not been carried out for a long time. The registered manager showed us a new appraisal document which had been recently introduced by the provider following feedback from staff across all of their homes. The registered manager told us she planned to arrange staff appraisals as a priority. Despite the lack of formal support, the staff we spoke with told us they felt supported in their role by the senior staff team.

Staff completed daily notes on the electronic care records system. Handover forms were also completed by staff to ensure important information about people was communicated to their colleagues on the next shift. We noted that the information inputted onto the electronic system was basic and repetitive. We discussed this with the registered manager who told us that further training was planned for staff with regards to improving their skills in this area.

During the inspection we observed mealtimes using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. There were three dining rooms and we observed the experience in them all.

In one dining room, there were 11 people seated at tables in the dining area. The tables were attractively laid out and people were sitting together at tables of two, three and four. There was music playing in the background, however the atmosphere was quite subdued. Two staff arrived to serve the meals to people and nobody needed assistance to eat. The meal consisted of soup, followed by sausages, mashed potatoes, carrots and gravy. Although staff offered people choices by asking, "Do you want to try the soup first" and "I will give you some but if you don't like it - you don't have to eat it", there was very little other interaction taking place. The people in the dining room did not interact with each other and there was hardly any talking throughout the 50 minute observation.

There was plenty of food available which was nicely presented and well-balanced. Staff offered people 'seconds' and most people appeared to enjoy the food. We heard some mixed comments which included, "It was lovely" and "The sausage is nice" as well as "I find it too salty" and "I don't care much for this soup". A domestic worker assisted the care workers by serving people who wished to remain in their bedroom.

A relative told us, "The food is great here". The kitchen had received a 5* hygiene rating from the local authority. We spoke with the chef about his involvement with people. He told us that he relied on memory and verbal information from the care workers as to whether any person had different dietary requirements to the planned menu. We observed the chef visiting people in one of the dining rooms and talking to them about their meals. We also observed him making alternative meals for two people in that dining room. We noted that during an internal quality outcome review which took place on 18 January 2016 it was recommended that, "A board is placed in the kitchen to show specialist and altered diets". This had not been actioned by the date of our inspection.

People, their relatives and staff told us that there was access to other professionals to meet people's general healthcare needs. We reviewed records which showed people had seen their GP, a dentist and a chiropodist. During our inspection, we spoke with a district nurse who visited regularly and an optician who visited the home periodically. They both told us they had no concerns about the home's ability to access external services for people. A relative said, "They noticed (Person) wasn't 100% and called her GP. She had a water infection". We found entries in the electronic care system were very limited with regards to the information

recorded about such visits.

The design of the home met with some best practice guidance around caring for people living with dementia. We saw that bedrooms doors were painted with contrasting colours from floors and walls. Areas of the home had been decorated in line with a theme, for example there was a 'pub' with a bar, tables, chairs and associated décor. There was also a 'library' themed quiet room overlooking the garden. The garden had areas for people to sit and admire the flowers and areas for people to do some 'gardening' tasks if they wished.

Good

Is the service caring?

Our findings

We observed a large amount of positive interactions throughout the inspection; staff were kind and compassionate and respected people's wishes. A relative told us, "We have been bowled over by how fantastic it is here, it's made the world of difference to (Person)" and "The staff are great, no matter what age or what role – they are all part of a good team". Another relative said, "The staff here have hearts of gold, anything I need to know they tell me".

The appearance of the home was very homely. One person told us, "I couldn't ask for anything better, if I have any problem they sort it out straight away". Most people living at the home had high needs and required assistance and reassurance from staff to ensure they were safe and well cared for. The staff we spoke with told us about people's needs and preferences and how they cared about people's well-being. There were many long term members of staff who knew people very well. The electronic care records contained some information which people had provided about their life histories, preferences, likes and dislikes, however we found these entries to be basic. We spoke to the registered manager about the level of details in these records. She told us she hoped this would improve following further care plan training for staff.

There were no restrictions as to when people could have visitors and we saw relatives and friends coming and going throughout the inspection. The staff appeared to know each visitor and always greeted them warmly and friendly. A relative said, "When you walk out, you feel that your mam is part of a family".

We saw evidence that the registered manager tried to involve people in the running of the service. Regular resident/relatives meetings were scheduled throughout the year. The last one was held in November 2015 where seven residents attended but no relatives. Four other meeting records were reviewed, however no families had attended. We read that people had been asked for their feedback and opinions on matters relating to the home.

We saw evidence of people's diverse needs being met. One person who spoke very little English had been given access to an interpreter to ensure he understood the issue being addressed. People with health conditions such as diabetes were given options of alternative meals to meet their needs. The activities coordinator took some people to church during the week. We saw that staff had received training in equality and diversity.

Staff respected people's privacy and treat people with dignity. We saw staff offering people an apron at mealtimes to protect their clothing and we saw staff closed bedroom doors when attended to personal care. The registered manager told us she had converted an unused room into a library themed 'quiet room' so that people had somewhere to sit for confidential conversations with their relatives or supporters. She also told us it had been used as a private space when relatives were bereaved.

We asked the staff about advocacy services. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Staff told us that the registered manager was aware of how to access a formal advocate if people needed this support, as she had arranged this in the past, although most people had family or friends who acted on their behalf informally.

During our inspection there were people receiving end of life care and support. Records showed that staff were trained in palliative (end of life) care. The electronic care records contained information about advanced care planning decisions and paper files held records to support these plans.

The home had recently dealt with bereavement and during our inspection we observed staff dealing with bereaved relatives with compassion and kindness. We also observed staff being particular respectful when assisting an undertaker with his duties.

Requires Improvement

Is the service responsive?

Our findings

The electronic care records system was capable of holding information such as, initial assessments, risk assessments, care plans, incidents, daily entries, likes and dislikes, medical and social history. There were sections entitled, "What is important to me" and "What people like and admire about me". This meant there was potential for the service to hold extremely person-centred information. However, we found there to be disparities in how each section had been completed by staff. For example, information about a person being diabetic was recorded in the 'Food and Drink' section, while the 'Medical History' section remained blank. Staff told us that one person "Falls asleep often"; however the 'Sleep Pattern' section remained blank.

The service used nationally recognised assessment tools such as FRASE (Falls Risk Assessment Score for the Elderly) and MUST (Malnutrition Universal Screening Tool). Although these were completed and a score was generated by the computer, these were not translated into an up-to date, thorough, person-centred assessment of how staff should provide care and support to each individual person.

Some records contained information in all sections, although we found it to be basic, brief and sometimes repetitive. Some sections were entirely blank. For example, we found some records contained no medical or social history. Some records did not have the 'one page profile' completed. There was some evidence that people and their relatives had been involved in planning their care and treatment. For example, some people had contributed by sharing their preferences with regards to a routine. Some people had shared their likes and dislikes and some people and relatives had provided staff with a life history. Although these detail were not evident in all of the files we reviewed. We also found differences between what was recorded on the electronic system and what was held in the paper files. For example, we found two paper records which stated people had a DNAR in place however this was not flagged up on the electronic system despite there being a specific place for this important information. We discussed our findings with the registered manager who told us she had recognised this and planned for staff to undertake further training in care planning.

Information was recorded manually by care staff regarding food and fluid intake, hourly checks, incidents and post-falls observation. The information regarding incidents was then passed to the deputy manager to input onto the electronic system. Due to the backlog of this task, frequent falls had not been highlighted to the registered manager using the automatic electronic alert system. This meant that the service had not responded quickly to meet the needs of some people.

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

Reviews and regular assessments took take place. The registered manager had introduced a "resident of the day" assessment. This meant that each day staff from different departments would visit the chosen "resident of the day" and discuss their care and support. This included care staff, kitchen staff and domestic staff. However, there was little evidence of thorough records being made about the conversations which took place.

Everyone we met with spoke highly of the activities coordinator. A relative described her as "Wonder Woman". The activities were organised and varied. There were appropriate activities on offer to suit people's needs which were managed on both an individual and group basis. Where possible people moved between floors to access different activities and mix with other people. We observed the activities coordinator escorting two ladies out in a taxi to visit another home in the community who were offering a bingo afternoon. We also observed a group session involving arts and crafts. The activities coordinator told us she spend some time during the week providing one to one support with people in their rooms if they wished. This time was often spent chatting and sometimes involved a manicure. People told us they enjoyed getting a manicure from the activities coordinator. The activities coordinator also told us that once a week they set up in the 'pub' room. She said, "Mostly male residents come along and play darts and cards or dominoes – it goes down well as it reminds them of the community".

Some people told us they would like to be escorted to the supermarket and have day trips on their own, but the service could not meet these expectations. One person told us, "When I first came here, they said I would be doing something every day and I'm bored because I just sit here and watch TV as I can't walk. I don't mix much with other residents". One member of staff told us, "The staff are too busy to sit and chat to people in the lounge because there is always tasks to do".

We reviewed the record of complaints received by the service and found there were no entries after September 2015. We discussed this with the registered manager because we were aware of two complaints which had been made about the service in more recent months. The registered manager was also aware of these two complaints and had been involved in managing the issues. Although she was able to tell us how theses were handled, she acknowledged that she had failed to record them in the complaints log. The complaints records we did review contained details of the complainant, investigatory notes and an outcome.

Requires Improvement

Is the service well-led?

Our findings

We reviewed the established policies, procedures and systems in place for the management of the service. We found that although these were well developed and thorough, the staff were not using them to their full potential. This meant the systems and processes were not operated effectively to ensure compliance with all of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the registered manager and staff could tell us about information we required, record keeping was poor and specifically there was a lack of written evidence in areas such as incidents (particularly falls), risk management, health and safety, complaints about the service and quality assurance.

The lack of constructive and motivating formal feedback to staff in the form of an appraisal meant that the registered manager could not ensure staff understood expectations, responsibility and accountability.

The electronic care records system included a manager's tool called I-perform. It is an automatic audit of the information which staff input into the system. However due to the delay in inputting information and the lack of detail, the registered manager had not acted on the concerns which we raised during the inspection related to incidents which had recently occurred. In the absence of good electronic record keeping, manual records or verbal communication should have taken place to ensure the registered manager was fully aware that urgent action was required. Due to the lack of this, follow up action had not taken place and medical attention had not been sought for two people. We discussed this with the registered manager during the inspection and she arranged the medical attention immediately.

Auditing of care records had not identified that a DNAR was wrongly in place for one person. A' best interest's decision had been made prior to a person's admission to the home and the staff had not identified this during their initial assessment. Reviews and audits which had taken place had also not identified this serious error. We spoke to the registered manager about this and she told us she would address it immediately, which she did by the end of the day.

The registered manager and the provider had identified most of the issues we found at this inspection through their own internal quality audit however they had not always addressed each issue in a timely manner. A 'Service Improvement Plan' conducted by the registered manager, dated 15 June 2015, recognised that care plans were not person-centred, people's consent to care and treatment was not evidenced on care records, best interest decisions needed to be carried out when a person's mental capacity was questioned and staff supervision and appraisals were overdue. We also noted that a list of incorrect information found during an internal care files review also remained unactioned at the date of our inspection. This meant that the service had been working on these improvements for the last nine months without addressing some high risk areas.

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

The registered manager told us that the provider was supportive and contributed to the service by visiting the home every month to check the quality of the service. The regional manager also telephoned the registered manager daily for updates. The registered manager submitted weekly and monthly reports to the provider about the management of the service.

We reviewed resident/relative surveys. The last survey in 2015 showed areas for attention which included hygiene, grooming and presentation of people, a malodour in the home and better activities provision. We saw that the registered manager had addressed these issues within an action plan, however as this inspection has shown some issues were still not fully addressed. A staff survey had also taken place within 2015 and the response rate was 67%. We noted that 94% of staff who responded were "proud of the work they do".

We reviewed thirty staff meeting records from meetings which were held across all departments. Separate meetings took place for senior staff, care staff, kitchen and domestic staff and maintenance staff. We read that key topics such as safeguarding, health and safety, care plans, rights, choices, privacy and dignity featured heavily in all of the meetings. Staff had an opportunity to ask the registered manager about issues which affected their work and we saw actions had been taken to address these. For example, new staff were being employed to assist the kitchen staff with deep cleaning, new equipment was purchased and repairs were undertaken.

The registered manager and the provider's representative told us about the staff recognition schemes in place. There were 'Gem' Awards for people and staff to nominate staff who had gone 'above and beyond' their duties. The provider hosted an annual national awards ceremony for 'Carer, Chef, Domestic, Maintenance and Activities Coordinator of the Year. There was also a 'Shining Star' Award which came from any compliments received from people and /or their relatives. Long serving members of staff were also awarded vouchers for five, ten years' service etc.

Staff told us the registered manager had a visual presence and was always available to talk to. A staff member described the registered manager as "supportive and approachable". The registered manager had a wealth of knowledge and experience in managing care homes. She had a thorough understanding of the requirements of her registration with the Care Quality Commission and submitted notifications to us without delay.

It was evident that overall people were cared for by the staff and people told us they felt safe and were happy. However, the governance of the service which underpinned all of the fundamental standards was not effective enough to ensure that people received high quality, safe care.

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 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	Regulation 11 HSCA RA Regulations 2014 Need for consent Care records contained no evidence that consent to care and treatment had been sought. Paper care records were not signed by people or someone acting lawfully on their behalf. Current legislation and guidance had not been followed by staff in order to gain consent for care and treatment. Best interests decisions had not been made or recorded in respect of this.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always reviewed following accidents and incidents. Staff were not doing all that is reasonable practicable to mitigate risks such as making referrals or seeking advice from external health services for people who repeatedly fell. Records were not always accurate. Care plans and risk assessments were not always completed for all care needs. Staff were not following their own medication policy with regards to self administration.

The enforcement action we took:

Served Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were in place but were not effectively used by staff. Risks were not being appropriately assessed and monitored. Records were not always thorough, completed, accurate and up to date. Where improvements had been previously identified, actions had not always been carried out in a timely manner. Audit and governance tools were not effective enough to ensure safety and quality.

The enforcement action we took:

Served Warning Notice