Meridian Healthcare Limited

Ashcourt Care Home

Inspection report

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Date of inspection visit:
12 October 2016

Date of publication:
05 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection took place on 12 October 2016 and was unannounced. At our last inspection in April 2013 we found the provider was meeting all the standards we looked at.

Ashcourt Care Home is a residential care home situated in Knotty Ash, a residential area in the suburbs of Liverpool. The bedrooms are all single occupancy with ensuite facilities and there is ample parking and large well-kept gardens to the front and rear of the building. There are several lounges, a dining room and a number of bath and toileting facilities on both floors.

There was a registered manager in post at the time of our inspection. This person was on annual leave. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Care plans contained risk assessments related to people's care and support needs, however these were not always completed fully clearly identifying the nature of possible risks or how care and support should be provided in ways which minimised the risk. For example, in all care plans we looked at the falls risk assessment did not draw any conclusion about the level of risk or how this risk could be reduced.

Care plans were reviewed at monthly intervals, with notes to confirm what, if anything had changed. However, we did not always see evidence of people's involvement in the review process.

The monitoring tools used to identify people at risk of malnutrition were being used to record people's weights on a monthly basis but we saw someone had lost ten percent of their body weight over two months, but there was no identification of risk or evidence any action had been taken.

We saw fire alarm tests and the servicing of the fire extinguishers were overdue. Staff told us they had received fire safety training, and records we looked at confirmed this.

We saw staff followed the correct procedure for administering medicines and supported people well. However some staff who administered medicines had not had their competency assessed checked regularly. Staff applied cream and lotions to people when this was required. There were no record to show where on the body this should be applied and how often.

Staff told us communication was a problem, for example a person had shingles and this information was not relayed to all concerned.

Appropriate background checks were carried out before new staff began working in the service.

The deputy manager and staff did not fully understand the principles and responsibilities in accordance with the Mental Capacity Act (MCA) 2005. We found staff did not fully understand capacity, which meant people may not be receiving appropriate support to make decisions.

We saw there was a programme of training in place which included mandatory training. A programme of regular supervision meetings and annual appraisals was in place.

The catering staff had a good understanding of people's dietary needs. We saw the food looked appetising and was well presented. People we spoke with told us they enjoyed the meals provided and there was always a good choice. Comments included, "The food is very good and there is always a good choice" and "The food and service is first class."

People told us they were treated with kindness and compassion. One person said, "Very happy. The staff are very kind. It's not what I thought it would be like, much better." Another person said, "Staff are very courteous. I'm happy with everything."

People told us activities were limited in the home. One relative spoken with said they had selected the home on the basis of its cleanliness and the range of activities apparently offered from Monday to Friday.

We saw the provider had systems in place to ensure any complaints or concerns were recorded and investigated. We received consistently positive feedback about the registered manager. There was an audit programme in place, however the provider did not always take robust action to make any necessary improvements.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe receiving care and support at the service.

Medicines were managed safely. However, some staff who administered medicines had not had their competency assessed regularly.

Risk assessments did not always include actions to minimise risk. Staff told us communication was a problem, for example a person had shingles and this information was not relayed to all concerned.

Is the service effective?

Requires Improvement

The service was not always effective.

Visitors told us they were pleased with the care, treatment and support their relatives received. They said the registered manager and staff were quick to inform them of any significant changes in their relative's general health which they found very reassuring.

We found staff did not fully understand capacity, which meant people may not be receiving appropriate support to make decisions under the Mental Capacity Act (2005). People did not always sign their care plans, and evidence of consent was not always in place.

People said they had good choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives expressed high opinions about the staff's caring nature. People said staff were kind and caring, treated them with dignity and respected their choices.

We saw details about people's preferred names, routines, hobbies and some information about how they may prefer care and support to be delivered. However, we did not always see evidence this was respected.

On the day of the inspection we found people were not always receiving person centred care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Systems were in place to assess people's needs. However, care plans and risk assessments were not person centred and people or relatives did not routinely sign the care plans.

People told us they knew how to make a complaint if they were unhappy and they were confident their complaint would be investigated by the registered manager and appropriate action taken.

People and their relatives told us activities were limited in the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People who used the service, their relatives and staff gave positive feedback about the registered manager.

The provider had systems in place to monitor and improve the quality of the service; However audit action was not always followed through in a timely manner.

Ashcourt 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.

Our inspection took place on 12 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert-by-experience who had experience of older people's care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 38 people living at the service. During our visit we spoke with 11 people who used the service, four relatives of people, eight members of staff which included the deputy manager, the assistant operation director and the operations director. We spent some time looking at documents and records that related to people's care and the management of the service. We looked at four people's care plans.

Before the inspection we reviewed the information we held about the service including previous inspection reports and notifications sent to the CQC by and about the service. In addition we contacted Healthwatch and the local authority who commission services from the provider to ask whether they had any feedback to share with us. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not provide any information of concern.

We sent a provider information request (PIR) before this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed what the provider had told us before the inspection.

Requires Improvement

Is the service safe?

Our findings

All of the people we asked, if they felt they or their relative was safe said they did. Most made reference to the security systems on doors; several said staff kept them safe, and some referred to the 'buzzers' in their rooms. They told us staff responded to these when used. One person said they specifically chose to come to this care home because they felt unsafe and afraid at home, but now feels safe. No one reported feeling unsafe around other people in the home.

In the PIR the provider told us, 'Ash Court review care plans each month and seniors will telephone families to check contact details are correct. This is an important part of the care plan process as things change and contacting family members can be crucial.'

Care plans we looked at contained risk assessments related to people's care and support needs, however these were not always completed fully, clearly identified the nature of the risk, or how care and support should be provided in ways which minimised the risk. For example, in all care plans we looked at the falls risk assessment did not draw any conclusion about the level of risk, or how this could be reduced. The assistant operation director acknowledged this and told us, "Our new risk assessments do not have scores."

We saw one person's care plan noted they had a pressure mat in place due to a high risk of falls, however the falls risk assessment in their care plan did not state they were at risk from falls or that protective measures had been put in place.

A risk assessment for a person who was registered blind, contained calculations undertaken at several intervals showing the level of risk, steps to take to reduce that risk, and a score for the risk if the control measures were followed. However despite the figures for the risk factors and control measures remaining the same over a period of time the up-to-date risk assessment concluded the overall risk score had been reduced.

One person had a risk assessment in place for a condition which caused them to experience hallucinations. The guidance for staff was basic, and suggested emotional support should be offered. The risk assessment lacked information about how to identify the person was experiencing the symptoms, what form the hallucinations took and whether they caused the person distress.

This was in breach of regulation 12. In safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at a sample of medicines and records for people living at the home as well as systems for the storage, ordering, administering, safekeeping, reviewing and disposing of medicines. Medicines were stored securely and the medication trolley was stored securely when not in use. We found there were adequate stocks of each person's medicines available and daily temperatures were taken of the medicines fridge.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These

medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The administering of these medicines and the balance remaining was checked by two appropriately trained staff.

The medicines administration records (MAR) contained a picture of the person to help staff identify who medicines were for, information relating to specific times medicines were to be given, for example 'before food', and any allergies the person had. We looked at 12 MAR sheets and saw they were correctly completed with no gaps.

We observed the medicines round. We saw the senior staff followed the correct procedure for administering medicines and supported people well. The trolley was always locked when left unsupervised.

Staff applied cream and lotions to people when this was required. These are known as 'topical medicines'. There were no record to show where on the body this should be applied and how often. We spoke with the deputy manager about this during the inspection. We were shown forms the home intends to use to record this information in the future.

We found some staff who administered medicine did not have their competency assessed as required. It was noted that the checklist for competency of staff members was not up-to-date and information was missing.

One person we spoke with said they experienced back pain. We asked them and their visiting relative about pain relief. We were told the person had experienced severe pain five days prior to our inspection. Both the person and their relative told us the staff had not responded quickly by providing pain relief or seeking medical attention. They told us staff had responded by saying it would be better to wait until after the weekend, when they could arrange for the person to see their own GP. The deputy manager told us this was not the case, the person was given pain relief and they wanted to see their own GP who was available on the Monday.

One person we spoke with said they had shingles and felt unwell and in pain, but the tablets they had been given helped this. We had not been told about this person's illness. When we returned to the person later to ask further questions, the senior staff member stopped us as we were entering their bedroom and explained that the person had shingles, and told us "I should have told you earlier, sorry." We later spoke to a staff member who said that they had also been into this person's room before knowing they had shingles and commented "We don't always get told things. Communication's a problem here." We found the poor communication of a person having a contagious illness posed a risk to staff, visitors and other persons from cross contamination indicating that the provider was not adequately ensuring people's safety.

This was in breach of regulation 12. In safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

In the PIR the provider told us, '87.9% of colleagues have completed our Safeguarding training and this is refreshed every 12 months. All colleagues are aware of the confidential Whistleblowing line. Colleagues are encouraged to report any incident or suspected safeguarding quickly, openly and transparently. Ash Court works closely with outside services and we include Care Line in all our safeguarding, this enables Ash Court to have contact with a Social Worker who can work together to define whether the referral is a safeguarding or a concern.'

We spoke with four care staff who demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they

could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy, and felt able to raise any concerns with the registered manager knowing that they would be taken seriously.

We saw personal emergency evacuation plans (PEEPS) were in place for people who used the service. PEEPS provided staff with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency. We saw evidence of PEEPS based on people's physical abilities, ability to understand verbal instructions and willingness to follow instruction.

We saw the weekly fire alarm test was last recorded as having been carried out on 24 August 2016, which was six weeks overdue at the date of our inspection.The servicing of the fire extinguishers was also overdue from September 2016 to the time of our inspection. Staff told us they had received fire safety training and records we looked at confirmed this.

We asked people if there was enough staff present to meet their needs. One person said, "There are not a lot of staff and the staff work long 12 hour shifts." Another person said, "They're very kind but they're worn out. They just don't have enough staff and also in the holidays there's been no-one brought in because [named staff] said it's not worth it."

We spent time observing staff and, saw people received prompt attention to requests for assistance and saw staff had time to spend chatting to people. Staff we spoke with told us they felt they were deployed in sufficient numbers to be able to meet people's needs safely. They said they may need to be present in higher numbers if the home was full, but told us they thought the registered manager would recognise this and act appropriately.

During the inspection we looked at the recruitment records of five members of staff. We saw these contained records of interviews and tests used to assess their suitability for their role. In addition the provider had undertaken background checks including employment references and checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about people who may be barred from working with vulnerable people, and making checks with them helps employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. People's comments included; "They ask me before they do anything." and "The staff are very helpful, they care for us very well here."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw inconsistencies in the way people's capacity to make decisions was recorded in care plans. One person's pre-admission checklist recorded they had full capacity, and we saw they had signed their own care consent. However, we saw an application had been made for a DoLS for the person on the grounds the person, 'Is unable to retain information relating to the need to stay at Ashcourt.' There was no documentation in their care plan which showed a capacity assessment had been carried out to capture any change in the person's ability to make decisions.

When we asked staff about DoLS applications, we received inconsistent answers. On arrival the senior staff on duty told us, "One or two people have a DoLS in place." The care worker was unable to tell us who these people were. The deputy manager told us no one had a DoLS and said, "This is something we know we need to do." When we looked at the records of DoLS applications we saw three applications had been made, although two of the people had passed away since the applications were made. There were no approved DoLS in place.

We saw the main entrance and exit to the home had a key code lock, meaning people were unable to leave the service freely.

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

We saw records which showed people had access to a range of health and social care professionals including GPs, district nurses, opticians, tissue viability nurses, older people's services and chiropodists.

We spoke with four visitors who told us they were pleased with the care, treatment and support their relatives received. They said the registered manager and staff were quick to inform them of any significant changes in their relative's general health which they found very reassuring. Comments included, "I am confident my relative is safe and is being well cared for," and "The manager always informs me if my relative is seen by their GP or if staff have concerns about their general health or well-being."

In the PIR the provider told us, 'Residents' nutritional and hydration needs are met taking into consideration their preferences, religious and dietary requirements with a view of minimising resident's weight loss. If specialist multidisciplinary team advice is required, referrals are made in a timely manner.'

We observed lunch in the dining room and noted the room was light and clean, overlooking the garden. The tables were attractively laid with cloths and napkins and set with cutlery; different cloths and flowers were used, when the tables were set for tea. A variety of assistive cutlery, plates and cups was also being used for people who needed these to help with eating and drinking safely. The dining room was quiet and calm, and people were sitting in groups. There was little conversation between people, other than on one table. There were two staff helping people who needed assistance with eating, another in general attendance and a senior member of staff overseeing meal time intermittently. Staff were attentive and patient, and we observed a staff member addressing a person by name and holding a conversation with them as they helped them, taking time to listen carefully to what they was saying.

We spoke with two people during this period. One person commented that the food was "Fine" although they couldn't remember what they had eaten. They told us they knew they would have selected their meal from a choice of two, and all other people asked during the day confirmed this. Another person said "The food's good and the dining room's nice and clean." We saw one person receive assistance to eat their meal in their bedroom. The staff spoke to them kindly and encouragingly, attempting to engage them in conversation and commenting on their hair.

Another two people were seen to have been offered lunch in their rooms, and one of them said they also had their breakfast in their room, by choice. One of them was supported by their visitor; the other person had refused lunch, saying they felt too unwell too eat. A member of staff offered a pudding, which they refused; this was overheard by the senior staff who intervened and asked the person to try to eat something.

We found members of the catering and care staff had a good understanding of people's dietary needs. We saw the food looked appetising and was well presented. People we spoke with told us they enjoyed the meals provided and there was always a good choice. Comments included, "The food is very good and there is always a good choice" and "The food and service is first class."

Care plans contained a Malnutrition Univsersal Screening Tool (MUST) which helps identify people at risk from malnutrition. We saw people's weights were recorded monthly, however this information was not used to calculate their body mass index or level of nutritional risk. This meant the provider was not using the MUST properly. One person's record showed they had lost ten percent of their body weight over a period of two months, but there was no record of what action had been taken in response. We showed this to the assistant operation director who was not able to tell us what had been done to assess and minimise this risk to the person.

The Waterlow pressure ulcer risk assessment tool was seen in people's care plans, however this was not always completed, meaning it was not being used effectively.

This was in breach of regulation 12. In safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Staff confirmed they received supervision where they could discuss any issues on a one to one basis. When we looked in staff files we were able to see evidence staff had received individual supervision and appraisal in line with the provider's policy. Staff said they felt comfortable to talk with the registered manager about anything and felt supported.

The deputy manager told us they had recently completed a staff training audit, and they had produced a training record, which recorded when staff had completed training. We saw following induction training all new staff completed a programme of mandatory training which covered topics as dementia awareness, infection control, emergency first aid and health and safety. Staff spoken with told us training was discussed during their one to one supervision meetings. The training matrix showed most staff were up to date with their required training. If updates were needed they had been identified and booked to ensure staff's practice remained up to date.

Requires Improvement

Is the service caring?

Our findings

In the PIR the provider told us, 'Each resident has a care plan in place which is fully person centred and is reflective of their current needs, choices and preferences. We support residents to be involved in their care planning and evaluation of care along with their relatives using 'Resident of the day.'

There was some evidence people were involved in the writing of their care plans. Some contained information about their preferences, for example we saw details about people's preferred names to be addressed by, routines, hobbies and some information about how they may prefer care and support to be delivered. However we did not always see evidence this was respected. For example in one care plan we saw the person preferred to have a shower at 6pm and to change into their nightclothes. The daily checklist for the person showed they had not had a shower at any time in October 2016 up to the date of our inspection.

Care plans and risk assessments contained prompts to add 'resident's views' for each section; however we saw these were routinely not completed.

People who lived in the home were asked if they were treated with kindness and compassion. One person said, "Very happy the staff are very kind. It's not what I thought it would be like, much better." Another person said, "Staff are very courteous. I'm happy with everything." Their relative commented "I've never seen anything untoward in four years and there isn't a big turnover of staff, which indicates something."

We observed staff assisting people very gently at all times; for example two people being transferred from their chairs to wheelchairs, using a hoist. These people were told rather than asked, before being moved. We observed they were relaxed and familiar with the process, because they were smiling and talking with staff during the process.

We noted one person leaving their room with a loaded trolley, including a cup of tea, and a bag. They told us they were 'going home to mum and dad' and attempted to use the lift. They were noticed by staff who were serving tea, who intervened gently and escorted them back to their room using soothing words and encouragement in doing so.

The staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. They also explained how they maintained people's dignity, privacy and independence; for example, by encouraging them to make choices about how they spent their time at the home and always asking them for their consent before assisting with their personal care needs. This demonstrated the staff had a clear knowledge of the importance of dignity and respect when supporting people and people were provided with the opportunity to make decisions about their daily lives.

Requires Improvement

Is the service responsive?

Our findings

In the PIR the provider told us, 'Care Plans are focussed on outcomes for Residents and they are person centred reflecting Residents' current needs, choices, abilities and preferences.'

We saw care plans contained assessments of people's needs carried out before they began using the service. This enabled the provider to be sure they could meet each person's care and support needs. In one pre-assessment we saw a note relating to an existing alcohol related brain injury, however there was no information relating to this in their care plan. We asked the deputy manager and assistant operation director if the person had an acquired brain injury and they did not know. They told us they would follow this up after the inspection, as the person's GP was also unaware of any acquired brain injury.

Care plans were reviewed at monthly intervals, with notes to confirm what, if anything had changed. We did not always see evidence of people's involvement in the review process. There was a prompt in the paperwork for the person or their representative to sign to confirm their agreement; however this was not always completed.

One person who we spoke with told us they had been unwell for the previous four days before the date of our inspection . It was said by their relative [name of person] had not had a wash in that time, as they was unable to do this for themselves as normal and staff had not offered help. Another person said they had a shower when they wanted, if one of their daughters was there to help (most days) and asked the staff if they wanted to have a shower any other time; when asked if this happened, they couldn't remember. Another person said they were helped with washing in their room but did not want to have showers because it was 'too hard to go all that way [from their end of the corridor to the other end].' Records from care plans reviewed did not evidence showers and baths were being recorded for this person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In person centred care.

We looked at the provider's policies and procedures for recording and resolving complaints and concerns. We saw all feedback including verbally raised concerns was recorded together with a clear course of action. There was detailed information about the issues and clear recording of action taken to investigate and resolve the concerns. This included ensuring the person raising the concern or complaint had the opportunity to discuss it with senior staff during any investigation and given feedback on the conclusion.

People who used the service and their relatives told us they were aware of the complaints procedures and would not hesitate to make a formal complaint if necessary. One person said, "All the staff are very approachable and although I have never had to make a complaint I am sure they would act appropriately if I had concerns about the care I receive." Another person told us, "I am very pleased with the care I receive but if I had any problems I would without doubt raise them with the manager to sort out." However one person said that 'nothing was done' when they complained about hygiene.

We saw no interests for individuals identified in their care plans and in discussion with staff and people we were told that activities at the home were limited and it was hoped that an activity co-ordinator would be employed in the near future. The deputy manager told us this was been addressed and members of staff carried out activities with people.We spoke with a visitor with a 'pat dog' who visited for a short period and who told us they were there weekly, at the request of a friend of one of the people living in the home.

We saw after lunch, the television was on in the lounge but all the people in this part of the room were asleep; a smaller number of people were sitting together in another part of the lounge and were happy to engage in conversation when approached. We spoke with two staff in attendance in the lounge; they were talking together and not engaged with the people and when asked if they were overseeing the people there, one said they were "waiting for the buzzers", indicating their 'pager'.

None of the eight people asked was able to describe any activities or entertainment provided by the home, or any support in pursuing their hobbies or interests, other than an Elvis impersonator reported by one person as having visited in March 2016. One person said that they was taken by bus once per week to another service, where 'they have entertainment' and described playing bingo. They did not know why they went and other people at the home also did not know. When; when asked, a staff member explained that this person went to a day centre before moving to the home and had continued to go since living at the home.

Several people reported enjoying reading, with books being provided by family and friends. One person said they went out each day alone, shopping or walking, as "There's nothing happening here." When asked about the garden, several people said it was very nice but a staff member said few people went into it and thought this was because they found it too cold outside most of the time.

One relative spoken with said they had selected the home for their relative on the basis of its cleanliness and the range of activities apparently offered from Monday to Friday. They were disappointed with the lack of available activities and had written to the provider in the summer of 2016 to complain. In reply, they had been told that an activities coordinator was being recruited, but nothing had yet happened. We concluded that activities did not regularly take place at the home

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In person centred care.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of the inspection. People who used the service, families and staff we spoke with during the inspection spoke highly of the registered manager. They told us they knew the registered manager by their first name and felt they could approach them at any time. One person said, "I can go and talk to the manager at any time. I go to her office and she always listens to me."

In the PIR the provider told us, 'Our Quality Assurance framework, Cornerstone consists of daily, weekly and monthly tasks and audits to help us assure good quality care.'

At the time of the inspection the registered manager was on annual leave. The deputy manager told us they monitored the quality of the service by quality audits, resident and relatives' meetings and talking with people and relatives. We saw there were a number of audits, which included care plans, health and safety and medication. However there were issues in relation to care plans. For example we saw one care plan had been audited by the provider, and we looked at the report dated 31 August 2016 during which several items had been identified. However there was no date by which the changes should have been made. We looked at the care plan and saw few changes had been undertaken. No other care plans had been audited, meaning the provider had not robustly checked the quality of care planning in the service.

We saw resident meetings had taken place to discuss menus and activities, last dated 19 April 2016. None of the people or their relatives spoken with said that they felt involved in the service or able to influence its quality. One person said, they had attended one meeting of the two held since they had come to the home in February 2016 . They said, "At this meeting, residents had been promised outdoor tables with parasols but that this hadn't happened." A group of people in conversation in the lounge later confirmed that this had been said, and that it was in response to residents' requests at the meeting.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance

The registered manager had sent out questionnaires to relatives and people living in the home in June 2016. We noted responses were mostly positive. Some comments included, "The staff are friendly." "We are all happy living here." People said they felt safe, the home was clean, staff treated their relatives with respect and staff had sufficient knowledge. However only 18% of the people said they were satisfied with activities offered in the home.

We saw staff meetings were held to ensure staff were kept up to date with any changes in policies and procedures and any issues that might affect the running of the service or the care people received. Staff said the registered manager was approachable and always had time for them. They said they felt listened to and could contribute ideas or raise concerns if they had any. They said they were encouraged to put forward their opinions and felt they were valued team members.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Evidence of consent was not always available and staff did not fully understand capacity, which meant people may not be receiving appropriate support to make decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had systems in place to monitor and improve the quality of the service; However audit action was limited and not always followed through in a timely manner.

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 Some actions identified to minimise risk were not always followed. For example, in all care plans we looked at the falls risk assessment did not draw any conclusion about the level of risk to the person or how this risk could be reduced. We saw fire alarm test and the servicing of the fire extinguisher were overdue.

The enforcement action we took:

We gave the provider a warning notice and ask them to comply with the Regulated Activities.