Dr Sunita Nagpal and Partners

# Salisbury Residential Home

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| 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

This inspection took place on 6 June 2016 and was unannounced.

Salisbury Residential Home provides accommodation and support to a maximum of 31 people. This includes older people some of whom may be living with dementia, people with physical disabilities, or people with mental health conditions. It does not provide nursing care. At the time of our inspection there were 25 people living in the home.

We last inspected this service on 30 June 2015 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of Regulation 17 as they had not identified some areas where actions for previously required improvements were still outstanding or had not been appropriately maintained. The provider was also in breach of the Regulation 11 because formal mental capacity assessments and best interests decisions were not always carried out and clearly recorded in people's care plans and Regulation 12 because people's medicines were not managed safely.

At this inspection in June 2016, we found continued breaches of Regulation 11 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

There was a manager in post who had been appointed in March 2016. At the time of our inspection, the manager had submitted an application to the Care Quality Commission (CQC) to become a registered manager. A registered manager is a person who has registered with the 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.

Some improvement was still required regarding the safe management of people's medicines. External medicines had not been stored securely and assessments regarding the administration of medicines were not reviewed. Staff were not always sufficiently trained and their competency was not always checked. This included the administration of medicines as some staff were not trained or assessed as competent to do so.

Staff had the knowledge to recognise, prevent, and report harm and knew how to raise concerns. They understood individual risks to people and how to manage these.

We received mixed feedback regarding whether staffing levels were sufficient enough to meet people's needs. We have made a recommendation that the service review this.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. Improvements were still required in this area as not all staff demonstrated knowledge of the MCA and DoLS and the home was not working within its requirements.

People's preferences and needs around meals were accommodated and people were assisted with eating and drinking when unable to do this for themselves. People were supported to receive the health care they needed. People at risk of not eating and drinking were identified; however where some people required their food and fluids to be monitored this was not always done.

People were supported by kind and caring staff, who ensured people felt involved and able to make decisions regarding their care. However some practices did not always promote people's dignity.

People and their relatives were involved in the planning and reviewing of their care. People and their relatives felt able to raise concerns. Concerns were listened to, responded to appropriately and action taken to resolve them.

People did not always receive responsive care that met their needs. There was a lack of daily planned activities for people living in the home and there was not always enough stimulation and activities for people.

The provider had not identified some areas where actions for previously required improvements were still outstanding or had not been appropriately maintained. Improvements were still required regarding the service's quality monitoring systems and some records continued to be incomplete and inaccurate.

People and staff were listened to and involved in decisions regarding the service, there was an open and inclusive culture within the home. Staff were valued and supported by the manager and provider.

## 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 at risk because some medicines were not stored securely or appropriately.

Staff knew how to recognise and report concerns regarding adult safeguarding.

We have made a recommendation that the service uses an effective assessment tool to ensure that adequate staffing levels are provided

### Is the service effective?

**Requires Improvement**

The service was not effective.

The home was not working within the requirements of the MCA and DoLS.

Staff had not always received sufficient training and their competency to provide some care tasks was not always checked.

People were assisted with eating and drinking when unable to do this for themselves. The monitored of people's food and fluids were not always monitored as required.

People were supported to receive the health care they needed.

### Is the service caring?

**Requires Improvement**

The service was not caring.

People and their relatives were encouraged, and had opportunities to be involved in decisions regarding their care.

People were supported by kind and caring staff, however some practices did not always promote people's dignity.

### Is the service responsive?

**Requires Improvement**

The service was not responsive.

People did not always receive care that was responsive to their needs and there was a lack of organised activities for people living in the home.

There were opportunities for people to discuss concerns or issues and people were supported to do so.

## Is the service well-led?

**Requires Improvement**

The service was not well led.

Quality monitoring was ineffective, this had resulted in a lack of improvement regarding issues relating to incomplete and inaccurate care records.

There was an open and inclusive culture, people and staff felt listened to and involved in decisions about the running of the service.

# Salisbury Residential 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.

This inspection took place on 6 June and was unannounced. The inspection was carried out by two inspectors and a pharmacist inspector. We did not request a Provider Information Return (PIR) form from the provider before this inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also contacted the local safeguarding team, quality assurance team, and health commissioners for their views on the service.

During our inspection we spoke with six people using the service and six visiting relatives. We spoke with seven members of staff. This included three care coordinators, two care assistants, the cook and a senior care assistant. The manager was not present at the time of the inspection. The provider was present and we spoke with them.

Not everyone living in the Salisbury residential home was able to speak with us and tell us about their experiences of living in the home. We therefore observed how care and support was provided to people and how people were supported to eat their lunch time meals.

We looked at four people's care records, three staff recruitment files and staff training records. Our pharmacist inspector looked at how medicines were managed in the service which included looking at people's medicines administration charts. We also looked at quality monitoring documents, accident and incident records, compliments and complaints records, and minutes of staff meetings.

Requires Improvement

# Is the service safe?

## Our findings

Our previous inspection on 30 June 2015 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines had not been managed safely.

During this inspection, our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. We found that some improvements had been made although some further improvements were needed.

Records showed people had received their oral medicines as prescribed. Our own audit that we conducted during the inspection confirmed this. However, we noted that for medicines prescribed for external application such as topical creams, there were gaps in the records of their administration. Therefore the records did not confirm these medicines had been applied as intended by the person who had prescribed them.

There was some supporting information available to staff to guide them on how to give people their medicines safely and consistently. This included personal identification and information about known allergies and medicine sensitivities to enable medicines to be given safely. However, there was no written information in people's care plans regarding their preferences in relation to how they wanted their medicines to be given to them.

For people prescribed skin patches to help control their pain, there were additional records about their application which showed that staff alternated the area they placed the patch. This was so that people did not experience undue skin irritation. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines. However, when people were prescribed more than one painkiller on this basis there was insufficient information to show how these medicines should be administered.

Some people's written guidance about their pain relief referred to pain assessment tools that staff should use in order to identify when pain relief should be administered. However, staff told us these were not being used. This meant there was a risk staff would not identify when pain relief was required. Staff told us about how medicines were obtained to ensure they were available to give to people prescribed them. However, we noted from the records that one person went without their prescribed painkilling medicine for six days placing their health and welfare at risk. Whilst the provider told us alternative over the counter pain relief was provided for this person, this was a concern as the prescribed medicines were not available to them as required.

Some people took their medicines themselves. The risks associated with this had been assessed but had not been recently reviewed to make sure it was still safe to them to do this independently.

Oral medicines were being stored safely for the protection of people who used the service and at the correct

temperatures. However, we found that some medicines prescribed for external application were not secure and were found in people's rooms. This placed some people who may not have understood what the medicine was at risk of accidental access to them and possible harm.

Staff we spoke with demonstrated they understood people's individual risks and how to manage these. Risk assessments were in place that were individual to people's needs and provided good guidance for staff regarding what actions they needed to take to reduce the risk of people experiencing harm. Risk assessments covered areas such as, falls, moving and handling, eating and drinking, and mental health. Risk assessments did not always contain risks that were specific to people living in the home. For example, we saw one person was at risk of self-neglect and there were no specific risk assessments in place regarding this. However, we saw there was guidance for staff in the person's care plan to ensure this risk was managed.

Risks to the safety of the premises were adequately managed and risk assessed. Regular up to date checks and servicing had been carried out on areas such as electrical equipment, moving and handling equipment, the water system, and fire safety. Records showed there were regular fire drills and care records we looked at showed people had their own care plan regarding fire evacuation. These actions helped ensure that the home was a safe place for people to live and work in.

People we spoke with told us they felt safe living in the home and relatives we spoke with agreed.
Staff had the knowledge to recognise, prevent, and report harm to ensure that people were protected from the risk of abuse. One member of staff told us they used a safeguarding checklist sent by the local authority to ensure safeguarding referrals contained the right information. We saw the home had a safeguarding folder which included guidance for staff and telephone numbers for raising concerns externally were on display in their staff room. The staff we spoke with also knew how to 'whistle blow' if needed.

We received mixed feedback from the people we spoke with and visiting relatives regarding staffing levels. Two relatives we spoke with felt staffing levels were sufficient to meet people's needs. One relative said, "There are always lots of [staff] about" and they had never observed their relative needing to wait for assistance. Another relative told us there was, "Definitely enough staff."
However, two people and one relative told us they felt staffing levels were not always sufficient.

Three staff we spoke with felt there were not enough staff. One said they felt an extra staff member would allow staff to interact more with people in the home. Another said they felt more staff would be of benefit as a number of people required two staff for support. One member of staff told us on occasion sometimes shifts were not always fully staffed. We reviewed the last three weeks rotas which showed on four days there were between one or two hours where there were less staff working than the provider told us there should be.

We asked the provider how staffing levels were calculated to ensure there were sufficient staff to meet people's needs. They were unable to tell us.

We recommend that the provider uses an effective assessment tool to ensure that adequate staffing levels are provided.

Staff files showed safe recruitment practices were being followed. This included the required character and criminal record checks, such as references and Disclosure and Barring Service (DBS) checks, to ensure the person was suitable to work in the home. Several staff who had started work recently in the home confirmed these checks were in place prior to them starting work.

Requires Improvement

# Is the service effective?

## Our findings

Our previous inspection on 30 June 2015 identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified concerns that formal mental capacity assessments and 'best interests' decisions were not always carried out and clearly recorded in people's care plans.

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.

We found that the service was not following the requirements of the MCA in a consistent manner. For example, where people lacked capacity to administer their medicines, a formal mental capacity assessment had been completed and a best interest's decision made when people were unable to make a decision about their medicines. However, other areas where people lacked capacity were not formally assessed. For example, one person had detailed information within their care record showing that they could not make decisions regarding their diet. There was no formal record to show the person's capacity had been assessed or a record of the decision made in their best interests. Where assessments of people's capacity to make decisions had been made these were not been regularly reviewed to ensure they were still relevant.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called 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 was being met.

The service had made applications under DoLS for a number of people living in the home. However, records we looked at showed the process had not been followed correctly in some instances. For example one person's mental capacity assessment stated they had capacity in this respect however a DoLS had been applied for. Another person's records showed whilst a DoLS had been applied for there was no MCA or best interests decision recorded. The provider told us that since the new manager had been in post they were working to ensure DoLS applications were made appropriately. The manager had identified and informed the local authority DoLS team of those applications that had been made incorrectly.

Not all staff we spoke with demonstrated they were familiar with MCA and DoLS. Four of the staff we spoke with could not tell us what a DoLS was and had limited or no understanding of the MCA. One member of staff said they were not sure if they had received training in MCA and DoLS. Another member of staff told us they hadn't received this training.

The above information meant there was a continuing breach of Regulation 11 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, there were seven members of staff authorised to handle and give people their medicines. However, three had not yet completed training in medicine management and two of the people administering people's medicines who had not completed the training had not been recently assessed as competent to undertake medicine-related tasks. Therefore people were not always given their medicines by staff who were trained and deemed competent. We raised our concerns with the provider who told us competency checks had been arranged for the following week.

People and relatives we spoke with told us they felt staff were sufficiently trained to meet people's needs. New staff completed an induction, which included spending time shadowing other staff. The provider and senior staff told us new staff had their competency checked before they were allowed to work on their own.

The staff spoke highly of the training provided and told us this had improved since the new manager had been in post. Records showed training had been planned throughout the year. A number of staff told us how the training was practical hands on training. Several staff said training was aimed at ensuring staff could understand the person's experience and how the care they provided impacted this. One member of staff said the training, "Makes you think" whilst another told us this had had a positive impact on staff's practice.

The staff we spoke with told us they felt supported to deliver effective care to people. Staff said they received regular supervisions and the manager was approachable and supportive. Staff told us they worked well together and supported each other to provide effective care. One member of staff said, "I have lots of people to reach out to for support."

People were supported to maintain a balanced diet. Several people told us the food was, "Good."
The service offered staggered meal times so they could ensure they provided assistance to people that required it. Where needed people needed one to one support to eat their meal, this was received. We saw support was provided at people's own pace and staff gently encouraged people to eat more when needed. Some people had specific adapted cutlery, crockery and drinking vessels provided which supported them to be independent with their meals.

People's particular preferences and needs around meals were accommodated. The cook told us they sought feedback from people regarding their meals and spent time with new people talking about their food preferences. The menu for the day was on display and different options were provided. One person told us staff knew what foods they were unable to eat and ensured they had separate meals which accommodated this. They went on to say if they didn't like any of the meals on offer, other options would be provided. Our discussions and observations of staff demonstrated they knew people's individual requirements regarding their diet and support.

The service ensured that care plans were in place to manage and monitor people who were at risk of not eating or drinking. We saw where people had been identified as at risk, their weight was monitored regularly and specialist health care professionals had been contacted when required. Care plans provided detailed guidance where needed regarding what people could and couldn't eat and how risks should be managed. This included where necessary keeping fluid and food charts to monitor how much people ate and drank.

We looked at two people's fluid and food charts. We saw whilst one had been filled in correctly the other had a number of gaps where meals and fluids were not record. This meant the risk to this person could not be accurately monitored and it was not clear the person had received sufficient fluids or food.

People received the health care they needed. We saw the service had set up regular meetings with their local doctor's surgery to improve communication, discuss any concerns and try to work together to avoid people being admitted to hospital. Records showed that where necessary people were referred for input from a range of healthcare professionals. This included referrals such as for nursing support or specialist mental health support.

Requires Improvement

# Is the service caring?

## Our findings

We noticed some practices that were not always respectful to people in the home. Although staff were always present in the middle lounge, staff did not always appear present in the front lounge where we saw three to four people sat throughout the day. One person in this lounge told us they had no way of calling for staff other than shouting. They said, "If I want to go to the toilet, I have to shout." They went on to say this caused them frustration and annoyed other people in the lounge who then shouted at them. We observed this to be the case and saw that staff did not always hear the person.

We also saw that information in relation to people's care were unsecured and kept in the lounge. This meant people's private information was accessible to other people and visitors in the home. These practices did not promote people's privacy and dignity.

Other people told us, and we saw, that staff treated people in a respectful manner. For example, we saw one member of staff who had just started their shift walk in to the lounge and say hello to each person in the lounge and engage in conversation with them. Staff were able to tell us about practical things they did which respected people's dignity and promoted people's independence. One family member gave us examples of how the staff had helped their relative be more independent since they had come to live in the home.

People living in the home and their relative's spoke highly of the home and the support provided by staff. Although one relative told us they felt a small number of staff could be, "A bit abrupt" with their relative. One person told us, "Staff are very good, I can't fault them." Another person said, "Staff are very caring." A relative said, "All the staff are very nice." Another relative said, "I'm quite happy with the care and the staff are very kind." A member of staff told us they felt staff really cared about the people living in the home and noted how important this was. They said, "That's the foundation isn't it."

Positive and caring relationships had been developed between staff and people living in the home. People told us and we observed that staff reacted quickly to comfort and reassure them when distressed. For example, we saw one person calling out in a distressed manner. A member of staff went over to them straight away and sat down with the person so they could discuss what was wrong and offer reassurance. We saw the person became calmer.

Our discussions and observations of staff demonstrated they knew the people living in the home well and could tell us about people's individual likes and dislikes. For example, we saw several people had difficulty verbally communicating however, staff could understand what they were trying to communicate.

People living in the home and their relatives told us they were supported to be involved in decisions regarding their care. We observed when staff assisted people they explained how they would assist the person and checked that they were happy with this. For example, when staff had to use moving and handling equipment this was explained to the person and staff checked that the person was comfortable and happy. On another occasion we saw a member of staff offering a person choice when asking them if

they would rather have their medicines before or after their breakfast.

Requires Improvement

# Is the service responsive?

## Our findings

People living in the home did not always receive responsive care that met their needs. One person told us, "I've got to wait about half an hour before I can go to the toilet." The person expressed frustration and unhappiness about this. A relative told us they had witnessed on a number of occasions that their family member had had to wait around forty-five minutes for assistance to the toilet. They said they had visited a number of times to find their family member had not been supported to get to the toilet on time and had subsequently needed to request staff to assist them with personal care. They went on to say this was distressing for them and their family member.

On the days of our inspection we saw that people who required two members of staff to help them sometimes had to wait for a second member of staff to be free. For example, we saw one person had to wait ten minutes before a second member of staff was available to assist them to the toilet. When they were brought back to the main lounge, they were left to wait in their wheelchair as a second member of staff was not available to help them sit back in their preferred seat.

We received mixed feedback regarding the support that was provided to people to enable them to participate in activities that complemented their own interests. We spoke with three relatives who said they were happy with the level of activities as their family member preferred not to engage in many activities. One said, "[Name] likes their peace." However, the two out of three of the people we spoke with regarding activities told us they felt activities could be improved. One person told us, "You don't do anything here at all; all you do is sit here." Another person said, "Activities could be a bit more I think."

Staff told us they all took responsibilities for activities. We spoke with five staff regarding activities; three of these staff felt activities could be improved. One member of staff said it could be difficult to provide activities amongst their other care tasks. Another member of staff said it could be difficult to provide activities that met the needs of all people living in the home because there was a range of abilities. Staff told us they would play music to people or a watch a DVD or on some occasions they would take small groups of people to a local café. We saw there was an activities board which showed some planned events such as a street style party and a trip to the local races.

On the day of our visit we saw staff played music for some people in the large lounge and encouraged people to sing along. We saw staff talking and interacting with people on a one to one basis. However we did not see staff engaging in long periods of interaction and this was often incorporated in to a care task. We saw there were little activities on offer for other people sitting in the other lounges. We concluded that activities in the home required improvement and did not always meet people's individual needs.

The concerns constituted a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some of the people we spoke with told us they received personalised care and we observed some examples of this. One person gave us a number of examples that demonstrated this. This included being given the

door code so they could leave the home and being supported to self-administer their medicines. Staff were able to tell us about people's individual preferences and how they supported people to receive individualised care. We observed people were able to spend their day how they wanted to, some people preferred to sit in their rooms whilst others had particular favourite lounges they wished to sit in. We saw one person enjoyed sitting outside whilst another enjoyed being in the garden and putting food out for the birds.

We reviewed four care plans and saw that these were specific to each individual and included their individual needs and how to meet these. The care records we looked at detailed people's personal preferences. For example, we saw people's care plans detailed individual times they wanted to get up or go to bed as well as whether they prefer baths or showers. However, there was a lack of information in some cases regarding people's personal history. Providing this information to staff can help them understand the people they are caring for in greater depth and helps ensure people have care provided in a way that takes into account their individual needs. The provider told us they were in the process of completing people's life stories and we saw evidence that confirmed this.

People and their relatives told us they had opportunities to discuss their care plans and how their needs should be met. A number of people and relatives told us when they first came to live in the home they sat down with staff to discuss their needs and how they wanted to be cared for. We saw one person's care plan showed they had recently had a review meeting with their family and staff to discuss their needs. The provider told us they were in the process of completing new care plans for people. They said they would be sending this out to people and their relatives so they could read and check them. This demonstrated the provider recognised the need to ensure people were involved and consulted regarding their care.

People and their relatives told us they felt able to raise concerns and confident that action would be taken to address these. One person gave us an example of a concern they raised. They said they felt listened to and immediate action was taken to address it. We looked at compliments and complaints records. We saw the service had received five compliments in the last year regarding the care provided. The home had received two complaints and we saw that these had been responded to and actions had been taken to address the issues raised.

We saw the complaints policy was clearly displayed in the home so people would know how to raise concerns. The service had put in place a number of arrangements to ensure they gathered from people their experiences and any issues they had. A suggestions book was also available in the entrance of the home and the home held regular residents meetings.

Requires Improvement

# Is the service well-led?

## Our findings

Our previous inspection on 30 June 2015 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified concerns that people's care records contained inaccurate information and some records had not been completed as required by the provider. We also identified that there were ineffective systems to monitor the quality of the service provided. At this inspection, we found that some improvements had been made but that the provider remained in breach of this regulation.

The manager was carrying out regular audits, these covered a wide range of areas such as safeguarding, medicines, staffing, nutrition, mental capacity, and training. We also saw that senior care staff were auditing care plans. However, these had not been sufficient to identify or address some of the issues we identified during our inspection.

In addition to quality monitoring audits the service also carried out a survey in 2016 with staff, people, their family and friends. Although these had been analysed, the analysis was insufficient. For example, we saw the only summary of the staff survey was 88.24% of staff were satisfied with the care given. However, we saw nearly half the staff surveyed had provided a medium to low score regarding staffing levels. This meant that areas of improvement had not been fully identified as a result and an action plan to address this had not been implemented.

A number of people's records were incomplete. For example, formal capacity assessments and best interests decisions were not always clearly documented in people's care records. We also identified some of the records relating to people's medicines were incomplete and there were gaps in one person's food and fluid charts. Another person's care record showed that staff had contacted the person's doctor regarding some concerns about their health. There was no further record to show what advice the doctor had provided and how staff should respond.

Care records contained inaccurate and out dated information. For example, one person's care records said they should avoid high stimulation environments and required fifteen minutes observations. A senior member of care staff told us this was no longer the case and the person's care plan did not reflect their current needs. People's care plans told staff to assess pain levels using a particular system, however on discussion with senior staff they advised that this system was not used.

Incident and accident forms were completed. These showed that staff had taken action to deal with the immediate situation. However, there was no evidence to show that actions had been considered or taken in order to mitigate the incident from happening again. For example, we saw one person had fallen three times in January 2016, there was no evidence that action to prevent further falls, for example a referral to a falls clinic has been taken. There was no evidence of detailed analysis of incidents and accidents this meant it would be difficult for the manager to identify any patterns or escalating needs so that appropriate action could be taken in response to this.

Although quality assurance processes and audits were in place and had identified some issues for improvement, they had not sufficiently identified all the issues that we had identified during our inspection. There were continuing concerns regarding inaccurate records and how people's consent and ability to make decisions was assessed. These areas had not been sufficiently improved since our last inspection on the home. This led us to conclude that systems and processes in relation to quality monitoring and driving improvements were not effective.

The above concerns meant there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers and registered managers are required by law to report incidents that can affect people's wellbeing by submitting statutory notifications to the Care Quality Commission. We found on one occasion a person living in the home had sustained an injury resulting in them being taken to hospital. This was not reported to us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People, relatives and staff told us the provider and manager were very visible in the service. One person told us, "I see [the manager] every week, she always pops her head in to say hello." One staff member told us they saw the manager eating lunch with people the other day. Several staff said the provider regularly visited the home and made sure they talked to people and staff. One member of staff said that whenever the provider visited, they always made sure they spoke to people living in the home and staff first and checked how they were. This showed the manager and provider encouraged open communication.

People and relatives told us they felt listened to and involved in decisions regarding the service. Several people told us they had been involved in decision regarding the redecoration of their rooms. The provider told us one person was involved in interviewing staff. We also saw there were formal resident's meetings for people which provided an opportunity for people to give feedback and discuss the service.

Staff told us they felt able to make suggestions and the manager acted on them. One member of staff told us, "[The manager] is definitely willing to listen to what staff have to say." Another staff member said, "[The manager] is always open for suggestions." They went on to give us examples of ideas staff had shared and how these had been acted on. This demonstrated an open and inclusive culture within the service.

Staff told us they were aware of their responsibilities. One member of staff said, "[The manager] is straight to the point" and clear on their expectations of staff. We saw minutes of staff meetings which showed the manager communicated staff's responsibilities and accountability clearly.

People, relatives, and staff spoke positively about the provider. A relative told us they felt confident in the provider whilst a member of staff said, "They're brilliant." We also received positive comments about the manager. One relative said, "[The manager's] responsive." One member of staff told us the new manager was, "Really proactive." Another member of staff told us they felt morale was good in the home and the manager and provider valued the staff. Several staff told us that although the new manager had only been in post a few months, they felt they had already been improvements to the service. One member of staff told us they felt shifts ran better and there was more interaction between staff and people living in the home. Whilst another said training had improved.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.<br><br>How the regulation was not being met:<br><br>The registered persons had failed to notify the Commission of an incident resulting in serious harm to a person. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.<br><br>How the regulation was not being met:<br><br>The service had not ensured that people received responsive care that met their needs.<br><br>Regulation 9 (1)(b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Regulation 11 HSCA (RA) Regulations 2014 Need for consent.<br><br>How the regulation was not being met:<br>Formal mental capacity assessments and 'best interests' decisions were not always |

carried out and clearly recorded in people's care plans.

Regulation 11 (1), (2) and (3)

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 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 HSCA (RA) Regulations 2014 Good Governance.<br><br>How the regulation was not being met:<br><br>The service had not taken sufficient action to assess, monitor, and mitigate the risks relating to people who used the service.<br><br>The service had failed to implement effective systems to assess, monitor and improve the quality and safety of the service.<br><br>The service did not maintain an accurate and complete record in respect of each person who used the service.<br><br>Regulation 17(1) and (2)(a)(b)(c) |

**The enforcement action we took:**

We have sent the provider a warning notice and told them they must be compliant with this Regulation by 13 September 2016