FitzRoy Support

Taylor Road

Inspection report

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Date of inspection visit:
23 August 2017
25 August 2017

Date of publication:
01 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 23 and 25 August 2017 and was announced.

Taylor Road provides accommodation and care for up to seven people with a learning disability. People living in Taylor Road may also have a sensory impairment or physical disability. At the time of our inspection, there were seven people being supported.

There was a registered manager in post. 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.

Some aspects of the service had deteriorated since our last inspection, when we rated it as good in all areas. We identified breaches of Regulations 12 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The safety of the service people received was compromised in some areas. This included risks to infection control within a kitchen area because of some damage that had not been repaired. There were also potential risks of accidentally swallowing or otherwise misusing toiletries including aerosols, a cleaning product and a thickening agent. The risks associated with insecure storage of these were in particular need of review following a change in the group of people living in the home. One person's risk of losing weight was not being fully addressed with remedial action in line with professional advice. Their risk of developing pressure ulcers was not consistently addressed and mitigated.

Systems for managing medicines needed some improvement to ensure prompt action was taken if anomalies arose. This included the need to respond more quickly to shortfalls in audits and to ensure medicines were always stored safely.

These concerns represented a breach of Regulation 12 for providing safe care and treatment.

We identified that there was also a breach of Regulation 10 for maintaining people's dignity and respect. The service was using monitors which broadcast what was happening in people's private rooms into a communal area of the home. This was not in line with the explanation the registered manager gave to us about its use and compromised people's privacy and dignity. We noted that there was some thoughtlessness in the use of the equipment as an intercom to communicate with one person in their room. Due to their additional conditions, this had the potential to cause confusion and distress. It was not respectful of the person's dignity or taking time to communicate with them properly, face to face.

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

We found that the systems for assessing the quality and safety of the service were not robust in identifying the issues that we found in relation to people's privacy, care records and risk management. However, we concluded this did not amount to a breach of specific regulations for the management of the service and the registered manager took action promptly to address important areas of concern. The provider's representatives had also completed checks on the quality of the service and drawn up action plans for improving where necessary. The management team needed to ensure that they sustained the improvements.

Other aspects of the service continued to work well for people living in the home. There were enough staff who were trained and competent to meet people's needs. They knew how to recognise and respond to any concerns that people were at risk of abuse and their understood their obligations to report such concerns. Recruitment practices contributed to protecting people from the appointment of staff who were not suitable to work in care services.

Staff understood their legal obligations in relation to seeking people's consent to deliver care. Systems within the service supported their practice and staff understood the importance of following guidance about people's rights and freedoms. They were aware of the importance of ensuring any action they took to support someone who could not make informed decisions, needed to take account of the person's best interests.

Many of the staff team had been in post for a long while and developed a good understanding of people's needs, preferences and what was important to them. This enabled them to deliver care appropriate to each person's wishes. They also understood any underlying health conditions affecting people's wellbeing and accessed advice from health and social care professionals to address these.

Staff spoke enthusiastically about their work and about current leadership arrangements in the service. They, and professionals providing support to the service, felt that the current registered manager was a good and approachable leader.

The registered manager understood their legal obligations in relation to issues they needed to inform CQC about and their accountability for operating the service properly.

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.

There were some risks associated with the premises, including the way that any outbreak of infection could be controlled and the storage of some products.

Although risks to individuals were assessed, they were not always managed robustly.

Medicines were not always managed in a safe way.

There were enough staff, properly recruited to support people safely.

Staff were aware of the importance of protecting people from the risk of harm or abuse and were aware of their obligations to report any such concerns.

Is the service effective?

Good

The service was effective.

People received support from staff who were trained and developed to meet their needs competently.

Staff supported people to make decisions about their care and followed legal guidance about acting in their best interests if they were not able to give informed consent.

People had a choice of food and drink and support with eating and drinking if they needed it.

Staff supported people to get advice about their health and wellbeing and the consistency with which they acted upon the advice was improving.

Is the service caring?

Requires Improvement

The service was not always caring.

There were occasions when people's privacy and dignity was

compromised and when staff did not fully take into account how they interacted with people.

However, staff did engage with people politely and respectfully and offered reassurance promptly when people needed comfort.

Is the service responsive?

Good

The service was responsive.

Staff understood people's needs and preferences, including their interests and friendships. They supported people in a way that took these into account.

People could be confident that the management team would listen to their complaints and concerns and take action to address them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's systems for monitoring the quality and safety of the service were not always robust and had not identified the concerns we found. The action that internal audits said was needed to improve, had not always been implemented and sustained.

People and staff were empowered to express their views and to raise issues with the registered manager.

Staff were enthusiastic about their work and the people they supported.

Taylor Road

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 23 and 25 August 2017 and was announced. The registered manager was given 24 hours' notice because the location was a small care home and we needed to be sure that someone would be in. It was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. They returned this promptly when they needed to and we reviewed its content. We also reviewed all the information we held about the service. This included the history of the management of the home and information about events taking place in the home and must be notified to us by law.

During our visit, we spoke with five members of staff and the registered manager. We spoke with four of the people who used the service. Some were not able to tell us clearly what they thought so we observed how staff interacted with them. We reviewed records associated with the care and medicines management of three people. We also looked at recruitment records for two members of staff, training records for the staff team and a sample of other records associated with the quality and safety of the service.

After our inspection, we asked the registered manager to supply us with some additional information. They supplied us with the action plan developed from the provider's quality checks and the staff training matrix. He supplied this to us promptly when asked.

After our inspection, we also received feedback from four health or social care professionals who provided support to people using the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service in May 2015, we found that people received a good, safe service. At this inspection, we found that some aspects of the safety of the service were not consistently as good as they should be.

There was some inconsistent practice in managing medicines safely. Staff were able to describe a safe process of administration and those spoken with confirmed that senior staff had checked their competence to do this safely. However, on the first day of our inspection, the staff member responsible for administering medicines in one part of the home did not retain the keys in their possession. They left them in a kitchen cupboard. This meant that they were not always stored as securely as they should be. On our subsequent visit, we noted that the staff responsible retained keys in their possession as expected, to minimise risk of their loss or unauthorised access. The registered manager confirmed they had reinforced the importance of this with staff.

We found concerns for the management of one person's medicines for managing epilepsy. Their second dose of one medicine was rescheduled on their medicines administration record (MAR) chart twice without satisfactory explanation. The person's MAR chart for June 2017 showed that staff were to give the medicine at 8.30am and 6pm. Their MAR chart for July showed the pharmacy had marked the charts for 8am and the second dose for administration at 9pm so they were more evenly spaced. Staff had given it at 9pm for a short period but changed this to 5pm during the course of the month. The registered manager was not able to explain the reason for the changes. They suggested the change was the result of a hospital appointment but could not locate information to support this.

The administration of the medicine at 8am and 5pm meant the person had nine hours between those doses but then did not receive their next dose for another 15 hours. We were concerned that, for best practice, staff needed to administer it at regular intervals. This was so the person could maintain therapeutic levels of the medicine and help control their epilepsy effectively. The registered manager acted promptly to seek advice after we raised our concern. However, routine checks and audits had not resulted in any action to verify what had happened.

We also noted that the same person had missed a dose of a different medicine for epilepsy that they should have three times each day. Staff had omitted to give the 1pm dose on 7 August 2017 and had given it at 5.30pm. This created concerns for the scheduling of doses and that the person had not received the medicine they needed to control their epilepsy in a timely way.

The medicines audit in June 2017 had highlighted that some staff were overdue for checks on their competence to administer medicines safely. The audit for July 2017 showed this shortfall remained. However, we could see from training records that this had improved recently.

There were appropriate arrangements to check and test emergency equipment, including that for detecting, containing and extinguishing fires. The registered manager took prompt action to update fire safety risks

associated with changes in the client group. However, there was one person using the service and who staff did not yet know well. We were concerned there may be additional risks to safety, which needed further assessment to ensure staff managed them. For example, a product for thickening drinks was accessible in a kitchen cupboard and presented the potential for a serious choking hazard if taken inappropriately. This was not previously considered a risk to people but needed reassessing following recent changes. We found bottles of shampoo, conditioner and aerosol deodorants as well as a foam cleaning product, openly accessible in one bathroom. This presented a risk if they were swallowed or otherwise used inappropriately.

We identified some potential risks to people's safety and welfare associated with the potential to control an outbreak of infection appropriately. For example, there was a 'kick board' missing under cupboard units in one kitchen. This left bare concrete exposed and the edge to the floor covering had lifted, both of which increased the risk of harbouring infection. A gap in the base of one kitchen cabinet allowed items to fall through onto the floor next to the washing machine, risking contamination. There was a strip missing between the corridor and one bathroom floor, presenting a similar risk of harbouring germs.

People had assessments of risks to their individual safety and welfare. However, staff did not always fully implement guidance for managing risk.

We noted that staff had not fully addressed one person's risk of weight loss in line with dietary advice contained in their care plan. Care records showed that the person needed full fat dairy products and sauces for example, to minimise this risk. The dietician's advice was that, if the person's weight dropped below 51 kg, staff should increase the person's calorie intake by fortifying their diet still further. We noted that staff recorded the person's weight on 19 August 2017 as 50.3kg. This meant it had dropped below the expected minimum.

This was only just before our inspection took place but their records did not show prompt action in response and staff did not have access to the range of products the dietician said the person needed. Semi-skimmed milk was available to the person within the home but not full fat milk as the dietician said the person needed on routine daily basis. This compromised the abilities of staff to mitigate and address the risk in line with the dietician's advice.

The same person's records contained an assessment showing they were at high risk of developing pressure ulcers. However, when we reviewed their assessments with their daily notes, their records showed they had experienced a suspected stroke in the past. This warranted an additional score on their risk assessment and indicated that the risk may have been underestimated.

To address the risk, staff were expected to assist the person to change their position regularly. The person's records did not consistently show that this happened. There were occasions when their records showed they had remained on their back for prolonged periods. There were also occasions when the records that staff used to record interventions were blank and so did not show how staff managed the risk by assisting the person to move. For example, on18 August staff had not recorded on the repositioning charts, any assistance to move between 5.45am and 4pm.

Staff told us that it was not always comfortable for the person to rest on either side rather than their back. However, when repositioning records did show the person was on their side for a time, their other records did not show that the person experienced discomfort or distress. The registered manager took action to seek further advice and update guidance after we raised our concerns. The service had not consistently demonstrated how they managed risks to the person's safety.

These issues represented a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed to us that the person had no pressure ulcers and could explain what they did to minimise risk, including the checks they made when they delivered personal care. We noted that they adhered to a health professional's recommendations for the maximum time the person spent in their chair. The person also had an appropriate pressure-relieving mattress in place. This contributed to maintaining the health of their skin.

Staff gave us consistent information about how they managed choking risks for people who had difficulties with swallowing food and drink. They information they gave us was consistent with the support plan provided by the speech and language therapist.

Staff had guidance about promoting people's safety in the event of an emergency. Equipment was tested regularly to ensure it remained safe and in good working order. This included equipment for detecting, containing and extinguishing fires. Staff had training to respond to an emergency such as a fire or an accident requiring first aid. There were contingency plans in place to promote people's safety and welfare should there be a failure for example of utilities, or the need to evacuate the home.

There were systems in place to help protect people from the risk of harm or abuse. Two people told us that they liked the staff. One of them told us, "The staff are lovely." They said they felt safe in the home. We noted that staff were aware of the potential impact of one person's distress and anxiety upon other people who were physically frail and vulnerable. They took action to adjust a person's routine to ensure they protected as far as practicable.

Staff were able to describe to us the signs that would lead to concerns someone was at risk of abuse or harm. They knew how people might be abused and were clear in their obligations to report such concerns so they could be properly addressed and protect people.

Staff told us they were confident they could raise concerns that people were at risk of harm or abuse and that the registered manager would deal with them. They were less clear where they could find information about referring abuse outside the organisation if they could not raise it internally for any reason. We checked with a staff member where they would find the information. They showed us information for staff in the policy guide for safeguarding. This contained the number for the provider's regional manager, local community learning disabilities team and the Care Quality Commission for advice. It did not include contact details for the local authority's single point of contact for referrals. However, relevant information was displayed elsewhere in the service. The registered manager agreed that they would remind staff about the information so they knew where to find the right details quickly.

People who were able to tell us, said there were enough staff to support them safely. One person said, "Staff are very busy but they were quick when I needed hoisting." Staff told us that they felt there were enough of them to support people safely. One commented, "We do get time to spend with people." However, staff were anxious about recent changes in the level of need of people using the service and the additional demands this created. One of the provider's representatives confirmed how this had been resolved to increase staffing levels at night. There was also an 'on call' system for additional support and advice to staff when they needed it in an emergency.

The registered manager and provider applied recruitment processes in a way that contributed to protecting people from the employment of unsuitable staff. They completed the required checks on the suitability of

applicants before confirming appointments. This included seeking references and enhanced disclosures to ensure applicants were not barred from working in care services.

Good

Is the service effective?

Our findings

At the last inspection of this service in May 2015, people received an effective service. At this inspection, we found this remained the case.

A person told us that they felt staff were trained and could use equipment like the hoist properly. They said, "Staff used to hoist me off my chair and into the bath…. They do things OK." A visiting health professional told us that they felt staff had supported people well with increasingly complex needs. They explained that they felt staff had developed their knowledge and skills with guidance from the registered manager so they could achieve this.

Staff told us that their training was good and there was a mixture of computer based learning and classroom learning. A new member of staff was clear about the training they were expected to complete and said that the registered manager had discussed their programme with them. Another told us, "The training is all well set out and it flags up when things are due so we can catch up and complete things."

Training records we reviewed showed that staff had access to a range of training including basic training to work safely, such as moving and handling, first aid, medicines management and health and safety. In addition to this, staff had access to specific training to help them support people living in the home. This included training in dementia awareness, supporting people to eat and drink, epilepsy and some aspects of mental health. Staff also confirmed that there were opportunities to complete further qualifications in care should they wish to do so.

There were regular staff meetings and we noted that the registered manager used these to share information and increase staff knowledge. They showed us how they were going to use a "knowledge quiz" about choking risks and swallowing difficulties to improve staff awareness in these areas.

Staff told us that they felt supported by the registered manager and that they received supervision. Supervision is needed so that staff have the opportunity to discuss their performance and development needs. The schedule displayed in the office showed when supervision was either scheduled or completed.

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.

There was clear guidance displayed in the office about the principles of the MCA and how staff should take these into account when delivering care. A senior staff member also showed us how the registered manager had provided a credit card sized summary of these principles, which they carried with them as a reminder.

During the course of our inspection, the registered manager attended a multidisciplinary meeting. This was to discuss a person's understanding of medical treatment they needed and to agree how this should proceed. This helped to ensure appropriate decision-making processes in relation to the person's health, their insight into their condition and their best interests.

The registered manager was able to show that applications for authorisations in line with the DoLS had been submitted to ensure that people's rights were protected. Outcomes for most of these were awaited and the registered manager was aware of the importance of ensuring the least restrictive options were used to promote people's safety.

We saw that staff asked people for their permission before assisting them, for example to move around the home and helping with personal care. Staff spoken with understood the importance of seeking consent before they delivered care. A person told us, "Yes, they ask my permission."

Care plans had a thread of information running through them to show people's ability to understand and consent to aspects of their care. They showed who was important to people and could help in the decision-making process to determine what was in an individual's best interests.

People had a choice of food and drink and support to eat and drink if they needed it. One person told us, "We get enough. I can go and get a drink if I want one." We saw that staff offered people drinks regularly and checked what they wanted to eat. For one person there was additional guidance about their fluids so that staff could be aware if they were potentially developing a urine infection and whether they were drinking enough.

The provider's own quality audit report suggested that the management team should develop more use of picture menus to encourage choice but this had not yet happened. The registered manager explained that people did participate in planning meals through discussions with staff. Staff supported them with 'on line' shopping for food so they could see pictures of different types of food and drink. However, they did agree with us that pictures of ingredients might not be as useful in making meal choices as pictures of completed meals that could be made from those ingredients.

People were supported to access advice about their health and wellbeing, including their mental wellbeing. Feedback from professionals in contact with the service showed that people accessed speech and language therapy, dieticians, physiotherapy and occupational therapy. They were also referred to members of the community learning disability team and psychiatric services if required. This was in addition to accessing advice from their local health services such as the GP or district nursing team.

One health professional commented to us that there had been issues about communication among the staff team but this had improved. They said that staff had not always properly handed over verbal information they provided at their visits in the past. They told us this was sometimes frustrating and had resulted in staff not implementing their advice consistently. They explained that they now followed their visits up with a telephone call to the registered manager or deputy manager. They felt that this, together with newer staff being more used to their roles, had improved consistency.

Another professional said they felt that staff had acted upon the advice they and their colleagues gave to

promote people's health and welfare. Two of them said that the registered manager was very good at keeping them up to date about people's needs and sought advice about people's welfare in a timely way.

Requires Improvement

Is the service caring?

Our findings

At our last inspection of this service in May 2015, people experienced a good, caring service. At this inspection, staff displayed caring and warmth to people when they engaged with them face to face. However, there were inconsistent approaches to upholding and promoting people's dignity and privacy.

Staff made use of 'baby' monitors for monitoring whether people might need assistance or support in their rooms. They were not always using the system in line with the description the registered manager gave us about its purpose and usage. The registered manager told us that it was used at night. The one waking night staff was expected to take the 'receiving' part of the equipment with them so that they were alerted promptly to anyone needing assistance in another part of the building.

However, we observed that, during the daytime there was an occasion when the system was in use and transmitting what was happening in a person's room into a communal area. This area was accessible to staff, to other clients and to visitors to the property. This represented an invasion of privacy by listening in to what was happening in their private accommodation and broadcasting it in a shared space. We could not see that this had been subject to proper consideration in line with current published guidance about the use of covert surveillance. Consideration of other, less intrusive arrangements for individuals was needed to enable staff to monitor individuals effectively without compromising their privacy and dignity.

We also observed that one staff member used the equipment as an intercom to call from downstairs to a person in their room on the first floor. This was to find out whether the person wanted lunch or not. The care records for the person concerned showed they had mental health issues, anxiety and visual impairment in addition to a learning disability. This did not demonstrate a caring approach to enabling the person to interact properly with staff. It had the potential to increase their anxieties by broadcasting a 'disembodied voice' into their bedroom rather than the staff member going upstairs to engage with the person properly.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where a person was more aware of, and able to exercise their wish for privacy, we saw that they had a key for their own room. They told us that they liked to keep it locked when they were not present and they felt staff respected their privacy.

We observed that interactions between staff and people using the service were polite and respectful. They were also cheerful and friendly, with some chatting laughter between them. Visiting professionals told us that they found staff to be caring and supportive towards people and that they showed concern for people's welfare. Staff took prompt action to offer reassurance and encouragement when people became distressed.

Staff supported people to make choices about their care, with input from their relatives if appropriate. People's detailed care plans contained pen pictures about what was important to them, including

information about who was important in their lives and could support them with decisions and choices about their care. We found that some records and reviews showed that relatives had assisted their family members and also how staff had tried to involve people in decisions. One visiting professional said that they felt staff were also excellent advocates for the people they supported.

Staff understood that two people using the service had developed a close friendship. One of those people needed staff to assist with positioning their wheelchair. Staff ensured that they assisted the person to an area where they could spend time with their friend as they wished to. Others were offered choices about where they would like to go and how they would like to spend their time.

We found that staff supported people at their own pace and were patient in their approaches. The registered manager told us how they had improved a bath so that this was more of a 'sensory' experience for people. They said that this helped encourage them to relax and enjoy their bath time with no expectation that staff would hurry them. One person was looking forward to using this when a health condition they had improved sufficiently.

We noted that the registered manager and deputy manager had achieved recognised accreditation in relation to good practice in supporting people at the end of their lives. They were sharing this information with members of the staff team. We noted that relatives of two people who had previously used the service had written in a very complimentary manner about the attitude and caring approach staff had shown at such a difficult time. Staff we spoke with were warm and emotional in their accounts of events. They told us how they had supported not only the people concerned but also others using the service to come to terms with the loss of housemates they had known for a long time.

Good

Is the service responsive?

Our findings

At our last inspection in May 2015, we found that people received a service that was responsive to their needs. At this inspection, we found the responsiveness of the service remained good. Visiting professionals reflected that staff had a good understanding of people's needs and consistency of care was improving.

One person told us how the service had helped them make progress towards their goal and recover their health and mobility. They described how this had made their life better. The registered manager was in the process of ensuring that people's personal goals and aspirations were broken down into smaller steps. They anticipated that the changes would help staff better recognise the progress people made towards achieving longer-term goals.

We noted that some elements of people's full support plans needed updating to ensure they reflected progress. This included for example, that one person had received a piece of equipment, which their main support plan said they were still waiting for. However, staff knew what was in place for them and how they were to support the person to use it.

A visiting professional told us that they felt staff had a good understanding of people's support needs. They described how the service had prepared thoroughly for one person's admission so the service could be sure they could meet the person's needs. They had completed assessments of the person's needs before they moved to the service. For another proposed admission, the registered manager had also gathered information about the person's needs from their previous service to ensure the placement would be suitable.

There was a core of long-standing staff who had developed a good understanding of people's needs and preferences. They were able to tell us about the sorts of things people were interested in and the signs that might indicate whether people were contented or not.

The registered manager had introduced suggested timings and activities to provide some structured guidance for staff about increasing people's social opportunities. We noted that people could freely access a selection of games, art materials, music and DVDs to use within the home. One person said, "I don't get bored." During our inspection, another person went out for lunch with a staff member and told us they had enjoyed it. On their return, they told us how they and their friend were planning a holiday together. Both agreed that they had chosen this from a brochure and were looking forward to their time away.

People had use of an accessible vehicle, driven by staff. This enabled people using wheelchairs to access the community and travel further afield when they needed to.

We saw that there was a system for receiving and investigating complaints. Where there may be concerns, a visiting professional was confident staff would advocate for people using the service. This would help them raise their concerns. Information about how to complain was available in an 'easy read' format using simple words and pictures. Staff could use this to discuss and explain with people if they wanted to. One person

told us that, if they had any concerns, "Staff sort things out for me."

We noted that there were no formal complaints raised. However, when there were informal concerns, we could see that the registered manager spent time discussing and resolving these with the person involved and their relative. There were clear records about the discussions and agreements made.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2015, we found that the service was well-led. At this inspection, we found that some improvements were needed. Systems were not always sufficiently robust in identifying the shortfalls we found. Records were not always up to date and lacked clarity for staff about mitigating some risks.

An audit in March 2017 by one of the provider's representatives had identified that tissue viability and pressure area support plans needed to better direct staff about their action, observation and reporting. We concurred with this view and found it had not improved sufficiently, despite the action plan indicating the work was complete.

People's individual detailed care plan files were not kept up to date. We found that risk assessments for one person had not been updated to reflect their current situation. The information said they were waiting for a particular piece of equipment to enable them to sit up for short periods. The equipment was in fact in place at the time of our inspection. Parts of their records were updated when it arrived, but others were not so they were inconsistent. However, this did not adversely affect the person as staff were very clear about how they supported the person to use it.

The same person had a "pressure area support plan" in their daily support folder, stating staff should assist them to change position every two hours. Because it was undated, staff could not be sure whether it was the most up to date guidance for the person. There was further guidance about managing pressure areas, also contained in the person's daily support folder. This stated that staff should assist them to move very two to three hours, not two hourly as their other guidance said. Staff had last reviewed it in June 2016. The registered manager took action to provide another set of up to date guidance for staff to follow, during our inspection.

There was some confusion about where staff recorded people's current weights. Some were on a weight monitoring record and some were on their nutritional screening tools. One person's records showed weight checks recorded in different places on both the 18 and 19 August 2017. We concluded that records were not wholly reliable and consistent in the information they provided for staff. They were not used in a way that made information easy to access for reference and, in relation to this person's weight, may have led to unnecessary disruption or intervention.

The registered manager explained how he was in the process of reviewing record keeping systems to see how these could be improved and showed us how this was progressing. We discussed with the registered manager the need to complete a thorough review of care plans, daily plans, risk assessments and daily records to ensure their consistency and accuracy.

We noted too that an internal quality-monitoring visit had identified an area of best practice for improvement and which remained outstanding. This related to increasing opportunities for people to communicate using pictures or photographs. This had not happened.

Routine 'housekeeping' practices were not robust enough in contributing to a safe environment. For example, a basket of toiletries was left on the floor of a bathroom/toilet. Aerosol cans of a cleaning product were left on top of the toilet. We also found a first aid dressing remained in a cupboard when it was no longer safe and suitable for use. The expiry date marked on the packet was June 1996.

Other systems for monitoring the quality and safety of the service were working well. This included checks on the safety of water storage systems and maintenance of equipment. In addition to visits by one of the provider's representatives to assess service quality, there were also 'desk top' audits. These reviewed that the expected checks were place and that any incidents or accident were analysed properly to see if improvements could be made. These audits had identified that further work was needed to develop Health Action Plans for individuals and this was underway.

There were regular spot checks on the safety of the service at night, completed monthly between January and July 2017. This helped to ensure that night staff were fulfilling their roles appropriately and offering people the right support.

People knew the registered manager by name. We saw that he maintained a regular presence in the service and that people interacted freely with him. Staff told us that they found him accessible, approachable and willing to listen to their views and suggestions. They also said that he was willing to accept when changes introduced were not working well and to review how the service was running. They were clear about their roles and the registered manager's expectations and felt that team spirit and morale was good. They spoke enthusiastically about their work and the people they supported.

Health professionals expressed their confidence in the current registered manager. One described the registered manager as showing strong leadership and working well and cooperatively with professionals. Another described him as being very good at keeping them and their colleagues up to date with changing circumstances and responding to queries. The content of letters of compliments to the service showed that people's relatives also found the registered manager approachable.

The registered manager had ensured he continued to develop their skills and practice so that they could share this with the staff team, offering support and coaching where necessary. This included training as a dementia coach to share best practice and reflect on how this may affect people using the service as they aged. He was also exploring alternative ways of checking and developing staff knowledge, using quizzes they could discuss within staff meetings. He, and the deputy manager, had also completed additional training to support people at the end of their lives. They were sharing information with the staff team to help ensure best practice in this area.

The registered manager was aware of the information he needed to tell the Care Quality Commission (CQC) about, and had made notifications to CQC as necessary. He also understood, as did the service provider, their legal obligation to display the rating awarded by CQC at the last inspection. They made sure this was visible both within the service and on the service provider's website.

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 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was compromised by the inappropriate use of monitoring equipment. Regulation 10 (1) and (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were risks associated with the safety of the premises, including access to substances that might be hazardous to people's wellbeing, and risks for infection control. Risks to the safety and wellbeing of individuals were not always robustly managed and mitigated. Medicines were not always managed safely and consistently. Regulation 12 (1), (2)(a), (b), (d), (h) and (g).