Adiemus Care Limited

Alexander Court

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 9 April 2015 and was unannounced.

Alexander Court is a service that provides accommodation for up to 47 people. It offers residential care and support for older people some of whom are living with dementia.

There was a registered manager in post. They had been seconded elsewhere during 2014 and returned to being in day-to-day charge of the home in January 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff knew the importance of recognising and responding to any indications which might indicate a person had been abused or harmed in some way. People's medicines were managed safely. However, staffing was not always maintained or deployed in a way that meant staff could intervene promptly to support people who became distressed or agitated.

Summary of findings

CQC is responsible for the monitoring the implementation of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS). Staff understood the importance of supporting people to make decisions and choices about their care. Where people had difficulties making decisions they were able to tell us how they would encourage the person to understand what was needed. However, there was some inconsistency in the way people's abilities to make specific and informed decisions were assessed in accordance with the MCA. The manager understood when an application to deprive someone of their liberty under the MCA and DoLS should be made.

People had access to enough to eat and drink but they and their family members did not consistently feel that the variety of food and interval between tea and breakfast was as good as it should be.

People were referred to their doctor or other professionals when this was necessary, to help them maintain their health.

Staff responded to people in a calm and kind and respectful manner when they were distressed. However, there were isolated occasions when people did not receive a prompt, compassionate and respectful response.

Staff recognised how they should support people with their personal care and people knew how to raise a complaint about any concerns they may have. However, people's needs for support and encouragement with social and recreational activity and stimulation were not well addressed. This had not been properly recognised within the provider's systems for assessing the quality of the service to drive improvement in this area. People were asked for their views about the quality of the service but improvements were not always made promptly. Shortfalls identified as needed within the provider's audits and checks were identified with an action plan for improving the quality of the service.

We found that the provider was in breach of three regulations. There were not always enough staff deployed to support people safely and people's needs and preferences for their hobbies and interests were not properly assessed and met. The provider had not notified the Care Quality Commission of an incident in the home affecting people's welfare and potentially, their safety.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff recognised signs of potential harm or abuse and knew what to do if concerns arose. However, staff were not always available to respond to people's needs promptly and ensure their safety.

Medicines were managed safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had gaps in their support and training to help them understand people's needs. They understood the basic principles of supporting people who were not able to make their own decisions although these principles were not always applied consistently. The manager was aware when an application to deprive a person of their liberty might be necessary.

People were supported to eat and drink enough but the variety of food and interval between tea and breakfast was of concern to some. People saw health professionals such as their doctor or dentist, when this was necessary.

Is the service caring?

Requires improvement

The service was not consistently caring.

Most of the time people were supported by staff who were kind, caring and respectful of them as individuals, but there were occasions when this did not happen.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People did not always receive care that met their needs and preferences, particularly in relation to their hobbies and interests.

People felt their complaints would be listened to and addressed.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The manager had returned to being in day to day charge of the service in January but there had been deterioration in the quality of the service in his absence. Neither during this absence nor after his return, was there a notification of the failure of the hot water system, which compromised the care of people living in the home.

The quality and safety of the service was monitored but improvements were not always made promptly.

Alexander Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9 April 2015 and was unannounced.

The inspection was carried out by a team of three consisting of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we looked at all the information we had available about the home. This included the information the manager returned to us before our inspection. 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. We also reviewed notifications made to us. Notifications are changes, events or incidents that providers must tell us about by law. We reviewed other information obtained such as concerns that were raised with us and received feedback from the local authority quality assurance team, safeguarding team and the district council food safety team. We used this information to help decide what we were going to focus on during this inspection.

During the inspection we spoke with 11 people who used the service, eight of their relatives and eight members of staff. We also spoke with the manager, operations manager and deputy manager. We looked at care records for seven people and medicines records for six people. We also reviewed records of food and drink for four people, the training log for all staff and recruitment information for two staff. We checked other records associated with the management of the service, including quality assurance checks and minutes of meetings held with staff and people living in the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People commented to us that there were not always enough staff. One said, "Most of the time there are enough staff here but sometimes they seem a little short of staff and then we all have to wait for help." Another said, "Staff work hard here but they're always busy. I have to wait [for help] in the early morning." A relative told us, "Most of the time there seems to be enough staff around but sometimes the staff seem very busy and everyone has to wait about 10 minutes for the call-bells to be answered." Another visitor said, "If staff shortages occur then there is a real problem and if [person's name] needs to go to the toilet it's hard luck and accidents can happen."

Staff told us that there were not always enough of them on duty because staff absence was not always covered. One said, "We cope staffing wise most of the time but often it is 'full on' and we pull the deputy manager in to help. Most people need doubles so that adds to the workload." They also identified that one person required three staff to assist them with moving and handling, for example to transfer to the toilet, because the equipment was difficult to move around on the carpet with two staff. They told us, "During the day the managers will help but at night with staff numbers it is almost impossible to manage. The manager says he is looking into it and has had discussions with the O.T [occupational therapist]. Things take time here." During the morning we observed that staff were still assisting people out of bed and with dressing at nearly 11am.

We found that the duty roster for the afternoon of our inspection showed that staffing levels were not as expected and confirmed what staff had told us about absence not always being covered. One relief member of staff was crossed off the roster and another staff member's name was crossed off for sick leave. The deputy manager told us it was his responsibility to arrange duty cover but had not been aware of the situation in respect of these two staff members due on shift until we pointed it out. He agreed with us that the roster indicated staffing was below expected levels and arranged to work the shift until 8pm to provide additional support.

During the afternoon, we observed that there were periods of time up to 15 minutes when people living with dementia were left in communal areas without staff being present. On one of these occasions, three of the five people we observed became distressed and in one case a person raised their fists to someone who was shouting out. Staff were not available to intervene promptly to prevent people from becoming distressed or aggressive to one another. We saw another person attempting to stand and walk who we later observed as needing staff support to move from the lounge to the dining area. We concluded that potentially this person had been at risk of falls from trying to mobilise independently. We also noted that another person had no interaction from staff to find out why they were not eating their lunch and drinking for a period of over 45 minutes although they normally ate independently. We concluded that the service was not always staffed to meet people's needs safely.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff recruited about a year before our inspection told us about the checks that were made to ensure they were suitable to work in care. This included completing an application form and interview, references and providing proof of their identity so that a check could be made to ensure they were not barred from this type of employment. We verified this from the recruitment record and found that the checks were in place before newly appointed staff took up their posts. However, we noted that the provider's application form did not ask prospective staff to provide the full employment history required by both current and previous regulations. We discussed this with the operations manager who undertook to address the matter at provider level with the personnel department. Our discussions with the manager showed that disciplinary procedures were implemented where there were concerns about the conduct of staff and so contributed to protecting people.

People we spoke with told us that they felt safe within the home. For example, one person said, "I feel 100% safe here" A relative said, "It's reassuring to me that [person] is here, safe and secure."

One person commented about the way staff managed emergencies. They told us, "I did have a fall but they dealt with it very well and made sure my family knew straight away." Another person told us how staff had contacted the doctor promptly when they had fallen. There was guidance for staff at the reception desk about how to respond to other emergencies such as equipment failure.

Requires improvement

Is the service safe?

Staff gave us examples of what might constitute abuse and understood the importance of reporting concerns or suspicions that someone may be being abused. They confirmed that they had received training to support them in this. We know that the manager has cooperated with the local safeguarding team when this has been needed. However, we found from the manager's information about training that safeguarding training was supposed to be renewed every year and that for some staff, this had expired during 2013.

Staff were able to tell us about the risks to people they were supporting and how they were managed. However, we found inconsistent practice in the way that risks to people were assessed and documented to provide further guidance for staff. For example, for one person we found that there was no assessment of the risk of falls and their 'personal safety risk assessment' was blank. The person did have an assessment of risk for developing pressure ulcers but this had not been updated when their skin condition changed so that the level of risk to the person was under-estimated. This was put right while we were present.

People were satisfied that their medicines were managed safely. For example, one person told us, "The staff look after my pills. It makes it easier because I used to get mixed up. I know I'm getting the right medication at the right time." A relative also described a person's medicines as, "…crucial and he gets it when needed."

We observed that medicines were administered and stored safely. We found that the medication administration (MAR) record charts were completed after people were seen as having taken their medicines and there were no gaps in the records in use. However, there was a lack of guidance in place for staff about the use of medicines prescribed for occasional use (PRN) and the circumstances that might suggest they should be given. We found that one person who was prescribed a medicine for PRN use was being given this regularly. However, the MAR chart was annotated on the reverse and showed that the medicine was given at the request of the person concerned. We spoke with the deputy manager about this who said they would seek guidance from the person's GP about the prescription.

Requires improvement

Is the service effective?

Our findings

People told us they felt that staff knew how to support them. One person said, "The staff know how to look after us. Even the people who are muddled." Another person told us, "The staff seem well trained - they certainly know what they are doing." A third person commented, "You see documentaries about care homes. It's only the bad news. I get wound up. Alexander Court looks after people properly." Two relatives told us that they were happy with what they described as "…excellent care."

Staff told us that they had a programme of induction to equip them for their roles, which lasted one week. They said they were then supported to meet people's needs by 'shadowing' shifts with more experienced staff. They told us that they had completed core training such as moving and handling, protection of vulnerable people and infection control and that some training was delivered on the computer as 'e-learning'. Our discussions showed that some staff had completed training in dementia care and that one had just started work towards a diploma in health and social care. A member of staff said, "As a member of staff I feel well supported. My training ….. is right up to date and I get a regular appraisal." Another staff member commented that supervision and team meetings had not been regularly held but were being arranged.

We found that a quality assurance check completed in March 2015 identified issues about gaps in the training and supervision provided for staff. This included training which the provider's information showed needed renewing regularly. Staff commented to us that the manager had been seconded elsewhere for some time, returning to the home full time just before our inspection. They felt that supervision and renewal of time limited training was likely to improve now he had returned. The manager was aware of shortfalls and of the need to review training and supervision schedules to ensure they made the improvements identified in the provider's quality assurance check. The operations manager was also aware of these issues and the need to ensure action was taken.

We found that the practice of ensuring decisions were made in accordance with the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS) was inconsistent and assessments were not always specific to the individual decisions needing to be made. For example, we found that one person's capacity to make an informed decision about their personal care had been appropriately assessed and a decision recorded that was considered to represent their best interests. However, for the same person a 'best interests decision assessment' referred to the decision required as 'mental cognition state' rather than being about a specific aspect of their care.

Although some staff had not received training to understand their responsibilities in supporting people who may lack the capacity to make informed decisions about their care they were able to tell us how people's choices were addressed. For example, one staff member told us how, if a person refused help with washing, they would try to distract the person, return later to offer the person assistance, or see if another member of staff could gain their consent for the support. We know from information sent to us by the manager before our inspection that an application under DoLS was appropriately made when someone's liberty was thought to be restricted.

People were satisfied that they had enough to eat. For example, one person said, "The food is wonderful. There's plenty of it and I lick my plate clean! I can eat in my room if I want to watch TV." Another person told us, "The food is fine and there's enough to eat and if I don't like what's on the menu I can have something else." A third person commented, "They come to check each day to see what I want to eat. I have a good breakfast so I don't always want lunch. They do lovely cheese and potato pie and roasts."

However, we received conflicting information about the quality and choice of food, as well as the scheduling of meal times. Five of the 11 people spoken with and two relatives expressed some concerns. Two people felt that the menu was repetitive. One person told us, "The food is nothing special." Another person said, "The food's OK but you don't expect too much when it's all served up at the same time." A relative said, "I've commented on the lack of variety of the food and been told the menu changes every fortnight. There seem to be lots of casseroles and of course it's sandwiches, sandwiches, sandwiches every tea time." One person told us, "You get plenty to eat here but the tea meal is a little early at 4pm and is always sandwiches. My daughter brings me in something nice for my supper because it is a long time to breakfast." A relative of another person who lived at the home told us, "My [relative] gets a bit peckish at night and likes a bit of supper, but the staff say there's not time to prepare some crackers for him as they tell him he has had his main meal." We saw that there

Is the service effective?

was access to snack foods and that toast could be made if this was required. The operations manager confirmed she had completed an unannounced check during one evening. This was to ensure that more sandwiches were available to offer people and that snack food was available in kitchenette areas. However, we concluded from people's experiences that the practice of offering these, or of making snacks, was variable and that the timing of the tea time meal did adversely affect some people.

We saw that people had assistance from staff to eat their meals if this was required. However, staff were not always available to ensure that people who could eat independently were prompted and supported to have an enjoyable mealtime experience. For example, we saw that one person living with dementia was walking down a corridor trying to eat their meal from a plate they were carrying. A staff member had to break off from assisting someone else to encourage the person into their room to sit and finish their meal. In one dining room the television was on in the adjoining lounge area and distracted people so that no conversations took place between people while they were having their meal.

The risks to people from not eating and drinking enough were assessed and we saw that staff encouraged people with drinks, which were offered regularly. Where one person was asleep when the meal was served, staff gently woke them and encouraged them to eat and drink. They then offered the person an alternative when they did not enjoy their meal. We noted that one person had their meal taken away largely untouched. However, they told us they were not hungry and the staff member told us that the person had eaten a large breakfast. This was recorded in their notes but we saw that there were gaps in records for monitoring that people had sufficient to eat and drink.

People told us that staff ensured they were able to see the doctor or other health professionals if this was necessary. One person told us how staff were quick in identifying if they were "…not my usual self…" and to contact their doctor if necessary. A person also told us how staff supported them with monitoring their blood sugars to ensure they remained well. We found that people had access to other health professionals such as the district nurse or chiropodist. However, one relative was concerned that an eye test they had expected the home to arrange had not happened when it should have done. Relatives told us that the staff ensured they were informed if anything untoward happened or the person they visited was unwell.

Requires improvement

Is the service caring?

Our findings

There was variable practice in showing how people were consulted about their histories and beliefs. For example, we found that information about this was not available in one of the care records we reviewed for a person living with dementia. This potentially compromised the ability of staff to engage with people meaningfully while they were delivering care and support.

Despite positive comments from people who were able to speak with us, our observations showed that the service was not consistently caring in respect of people who found it more difficult to express their views appropriately. For example, a staff member discussed care of a person using the service with their relative in the corridor in a not wholly respectful manner. We observed that this was also in the presence of two other people living with dementia, neither of whom was the person concerned. This compromised the person's privacy and dignity. The staff member described the person using the service as "…crafty." They went on to say this was because the person would shout out for help but when staff went to them they would say nothing and just sigh if staff asked whether there was anything they could do. We observed that another staff member did not respond when a person in the lounge spoke to them and shouted out. One staff member walked past someone sitting in the corridor calling, "Please help me" without engaging with them although we noted that shortly after that a member of the ancillary staff did stop to ask them what was wrong.

People spoke positively about the approach of staff and their attitudes. For example, one person said, "I like the people who work here because they treat me as if I really matter, rather than it being just a job to them. They are so patient and understand when we just need time to be on our own or when we would like company." Another said, "I get to know the carers and they get to know me. They address me by my name and treat me as a person - that is nice because when you are giving up your independence and leaving your home it's easy to lose a sense of who you are." Relatives also commented positively about the attitude of staff. One visitor told us, "I really feel that I know the staff well and they always acknowledge me and speak so kindly to my [relative]." Another said, "It's more than a job to these people." Visitors said they were made welcome in the home.

A relative told us, "The staff are always polite and I think they know how to get the best out my relative who can be difficult at times because they get frustrated. The staff seem good at calming them." We observed that, when staff intervened to support people who were distressed, they did so in a kindly and caring manner. They offered comfort and reassurance and people who were agitated became calmer in their presence. However, staff were not always able to do this promptly and to ensure people did not become distressed. We saw that two staff assisting someone using a hoist dealt with the person respectfully, taking great care and speaking in encouraging tones as they undertook the task of moving them into a chair. We noted that staff closed people's bedroom doors when they were assisting them with personal care so promoting people's dignity and privacy. We saw that one staff member asked someone discreetly whether they needed assistance to use the toilet.

Where people were able to do so they were involved in decisions about their care. For example, one person said, "A senior girl went through my care plan and asked if I agreed to it. I had a review a while back. They're always asking how I am." Another said, "I am given a choice by the staff of what I wish to eat, drink and wear and I can get up and go to bed when I like." Relatives told us that they had been consulted about care for the person they visited and that staff supported people with their independence. One visitor commented that the person was encouraged to clean their own teeth although they required additional support with other aspects of their personal care such as showering and washing. Another relative said that the person they visited was encouraged to do as much as they could for themselves.

Requires improvement

Is the service responsive?

Our findings

Staff were able to tell us about people's personal care needs and what assistance they needed for example with washing and dressing or managing continence. Care was focused on meeting these physical care needs. We saw that two staff went to attend to someone's personal care needs after lunch to ensure they were clean and comfortable. Most plans of care we reviewed were individual and personalised but were not all complete and had not been regularly reviewed, including when people's needs changed. Staff were aware of this, confirming that care plans were not all up to date and action was planned to update them. The support people needed with their hobbies, interests and recreational needs was not consistently identified in people's plans of care and people we spoke with did not feel that the service met their needs in these areas.

Staff and the manager told us how the activities coordinator had developed a group called 'Nan's Pantry' to taste food items that were once popular but were less so these days. People were supported to try these foods and engage in reminiscence. The manager also showed us a 'Memory Tree App' being used to build up a database to reflect people's memories of times past and their interests. However, there was no indication that information was incorporated into plans of care and being used for the benefit of people who lived at the home.

One person told us how they liked to spend their time and that they could find things to occupy themselves without much staff support. They told us, "I am not an organised events person." They went on to say that staff knew about their interest in sport and that they would sometimes watch television coverage late into the night. Another person told us how they usually declined to take part in the activities offered. However, other people spoken with gave us consistent information about the lack of opportunities for stimulating and interesting activities. For example, one person told us, "There's nothing to do here so I just sit, look and listen. Look at the others - that's why so many people are sleeping. They don't know what else to do." Another said, "There's absolutely nothing to do. I'm sat here in front of the TV but I'm not actually watching it. It can't be good for my brain, but I've just got programmed to sitting here." A third person commented, "There's not enough to do here and my fear is I will just lose my independence if I don't keep busy. We need encouraging to do activities of course but there's nothing to encourage us."

Relatives also expressed concerns to us about the lack of regular activities available for people. One commented, "I think that if there were more staff there would be time for residents to take part in more activities." Another relative said, "Activities, what activities? [Person] gets up in the morning and is put in the TV lounge, other than when the weather is nice and [person] can sit outside. They are all left to their own devices." One visitor felt that the provision of activities for people had declined. They told us, "Now hobbies and activities is a bad area. I've heard people say you can't make people do things, but you know I remember when there were things going on here and there was a good take up. So I know it can be done."

A staff member agreed that activities were a problem. They said, "We do have a lady who does two days a week and often she gets pulled into care as she's a qualified carer. When she tries to do something participation is so low that everyone ends up with no enthusiasm to do anything." They went on to say, "I know residents are bored and need more." Staff told us there should be two staff allocated for activities but there was only one in post.

From our observations we concluded that care staff had little time available to spend with people to engage them in discussions or activities and predominantly relied upon the television as a distraction for people. We observed that the television was on in the lounge on the first floor of the home for much of the day. During the afternoon people were not consulted about a film that a staff member selected. Two people said they had seen the film 'Bridge over River Kwai' before and three said that they did not like war films. Their comments were not acknowledged by staff. One staff member suggested that perhaps a musical such as 'Annie' would be more appropriate but no action was taken. People were not consulted and their comments were not responded to.

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

People told us that they were able to raise concerns or complaints with the manager. One person told us, "If it's something minor I would go to the senior. If it's a major

Requires improvement

Is the service responsive?

thing I'd go to the manager and he would sort it out." Another person told us, "I have no reason to complain." A third person told us, "My complaints have been listened to and sorted out." The majority of relatives spoken with were satisfied that action would be taken to resolve concerns. However, one commented, "The night staff are never as good and just don't give the same degree of care and attention. I made a remark in [person's] folder that the bumper cushions [to prevent the person falling from bed and hurting themselves] were covered in sticky dried drink. No one had cleaned it up and I didn't get a response."

Requires improvement

Is the service well-led?

Our findings

We found that there had been long term problems with hot water supplies in the home, with a lack of hot water to large parts of the building. The matter had been commented on at a residents meeting in December 2014 and remained a problem. Staff told us that they had to carry hot water through the home to people so that they could wash. This presented a potential risk. Some people had not been able to have either a bath or a shower for a prolonged period of time because of the problems.

A member of cleaning staff told us that at times, they washed floors and cleaned rooms using cold water. We raised this with the manager and operations manager who accepted our concerns and told us that there had been various efforts and considerable expense to rectify the problem but these had not been successful. We emphasised that this needed urgent attention due to concerns for people's welfare and the management of risks of infection. We received confirmation shortly following our inspection that repairs had been made and there was a good flow of hot water throughout the building.

However, the manager had not notified the Care Quality Commission at all about this as an event affecting the proper and safe running of the service, so that we could monitor the actions taken. **This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.**

All but one of the people spoken with knew who the manager was and found him approachable. Two people told us that the manager spent a lot of time in the office and one did not know who was in charge of the home. For example, one person told us, "The manager is friendly although you don't see him around a lot. He's been around today though - maybe he's checking up on you!" Another person said, "I don't know who is in charge; in fact I'm not sure anyone is in charge." Although the manager emphasised to us that there was an 'open door policy' for receiving people's views, we concluded that a proactive approach to consulting people was not consistently initiated by the management team.

Relatives told us that they knew who the manager was and were asked about the quality of the service. There were also meetings to discuss the quality of the service involving people living in the home and their relatives. However, some frustration was expressed to us about the length of time it took to respond to suggestions for improvement. For example, one visitor said that the manager was good at dealing with relatives but went on to say, "He needs to have an impact around the place. He tends to be in his office. He always says, 'If there's a problem, come to me.' He doesn't fill me with confidence that things will get done. I know at the residents' meeting there were comments made about the need to improve the food, but absolutely nothing was done."

Staff commented that the support they had from the manager made them feel valued, although they were not aware of the processes used for checking the quality of the service and could not remember being asked formally for their views, for example using a survey. They expressed some frustration that they could not always see action as a result of discussions at staff meetings. For example, they said they had also been told that staffing levels were being reviewed but had not noted any improvements.

There was a registered manager in post. We were notified that the manager had been seconded elsewhere from November 2014 and had not returned to provide full time management support to the home until January 2015. The notes from the first staff meeting following the manager's return indicated that there had been issues relating to team work, the mealtime routine (including that there was a long time between tea and breakfast the next day), and reference to some deterioration in the service. Staff said they were glad that the manager was back and he was making improvements. They added that they felt the service was becoming better organised since his return.

There was a range of checks and audits carried out within the home and on behalf of the provider of the service, to monitor quality and identify shortfalls. However, we found that the quality assurance audit for activities did not raise significant concerns. This contrasted sharply with what people living in and visiting the home told us consistently. There had been an audit of care plans completed in November 2014 but this did not identify the gaps in records which we found and that reviews were not always taking place promptly. The provider's quality assurance processes, taking into account their need to comply with regulations, had not identified that full employment histories were required for staff appointed and had been required by the previous regulator of care services.

Requires improvement

Is the service well-led?

We noted that there had been an audit of staff training which identified shortfalls, particularly in relation to time limited training that was due for renewal. The manager and operations manager were aware of this and prioritising training to address the deficits. Accidents and incidents had been reviewed to see whether remedial action was needed to address any patterns and the risk to individuals. Staff were able to tell us what action had been taken and who had been consulted for professional advice when one person had experienced a number of falls. This showed that action was taken to promote the person's safety and to minimise or remove avoidable risk.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing levels and deployment were not always sufficient to meet people's needs.** Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's needs and preferences, particularly in relation to their preferences for meaningful activity, were not consistently identified and their care was not designed to meet these needs.** Regulation 9(3)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered persons had failed to notify the Commission of the failure of the hot water system as an incident affecting the health, safety and welfare of people living in the home.** Regulation 18(1) and (2)(g)