Abbey Healthcare (Westmoreland) Limited

Kendal Care Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place over three days on 8th, 9th and 12th February 2015.

At our previous inspection on the 13 October 2014 we found that the provider was still in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because medicines were not being managed safely.

We took enforcement action and issued a warning notice to the registered provider and registered manager that required them to make immediate improvements in relation to the way medicines were managed and monitored. The registered provider wrote to us and gave us an action plan saying how and by what date they intended to improve the way medicines were managed in the home. They planned to clarify arrangements for medicines supply for residents admitted to the service, review the administration of medicines to ensure that this was timely, improve record keeping and to provide staff training and assess competencies in the task of medicines administration.

We had also inspected Kendal Care Home on 7 January 2015 in response to a whistle blower raising concerns over staffing levels in the home. At the time we visited we found that the service was appropriately staffed to meet the needs of the people using the service. At this inspection on we found that the registered provider had made the improvements needed to meet the requirements of the warning notice issued to them. We

Summary of findings

found that medicines were being kept and administered safely in the home and storage was clean, tidy and secure so that medicines were fit for use. All of the people we spoke with who lived in the home told us that they felt safe living there.

However at this inspection we found that there were others breaches of regulations that had an impact on people living in the home.

Kendal Care Home provides nursing and residential care for up to 120 older people, some of whom are living with dementia. On the day of the inspection there were 73 people living there. The home is over three floors and has a passenger lift for access to these. There are three suites in the home and all the bedrooms are single occupancy with ensuite facilities. Each of the three suites has communal dining and lounge areas. There is a cinema room for people to use. The home is set back from the main road, with level access grounds. There is ample car parking for visitors.

The service did not have a registered manager in post at the time of the inspection. 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 and associated Regulations about how the service is run. The registered manager had recently resigned their post. The registered provider told us that they had recruited a suitable applicant who would have to register with CQC when they took up the management post.

The service has long standing difficulties with recruiting suitable staff and we saw that staffing and skill levels could still fluctuate, despite the use of agency staff. People living there could not be certain staff levels and skill mixes could be sustained in the long term to make sure there were always enough skilled staff to support and care for them.

The service was not being effective as records that we saw indicated that areas of staff training were not up to date or organised for renewal, although this need had been identified. Records did not provide evidence that both permanent and agency staff had also had training and formal supervision that was relevant to their roles and duties in the home.

We found that care assessments for some people living there had not been updated to provide a person-centred strategy to ensure appropriate support and use of medicines during end of life care.

The service was not being consistently well managed. We saw the systems used to assess the quality of the service were not always identifying quality issues. The management of the service had changed again as the registered manager had resigned so a deputy was running the service until the new manager took over.

We have made a recommendation about recruiting suitable staff to permanent roles so that a stable and skilled workforce can be maintained.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to staff training, skills, care assessments and not monitoring the quality of service provision well enough. These regulations correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found a breach of the Care Quality Commission (Registration) Regulations 2009 because the provider did not have a registered manager in place at the service.

The registered provider had systems in place to make sure people living there were protected from abuse and avoidable harm. They also had safe systems for recruitment to make sure the staff taken on were suited to working there.

The environment of the home was welcoming and the communal areas were decorated and arranged to make them homely and relaxing. Where people were living with dementia there was highly visible signage to show people what different areas of the home were for. This supported their independence.

People knew how they could complain about the service they received and were confident that action would be taken in response to any concerns they raised.

People we spoke with who lived in the home told us that they made decisions about their daily lives. All the visitors we spoke with told us that staff made them welcome when they came to visit or when they wanted to speak with them. We saw that people who needed support to eat and drink received this in a supportive and discreet manner.

Summary of findings

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves. The service worked with health care professionals and external agencies to provide appropriate care to meet people's physical and emotional needs.

You can see what 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?
The service was not safe.

Requires Improvement

The recruitment system had not operated effectively to make sure that new staff that had been employed met the conditions of the regulation.

There were sufficient staff available to meet people's needs but staffing and skill levels could still fluctuate, despite the use of agency staff.

Staff understood their responsibility to safeguard people and what action to take if they were concerned about a person's safety or wellbeing.

People were protected against the risks associated with use and management of medicines. Medicines were administered and recorded correctly and were kept safely.

Is the service effective?
The service was not effective.

Requires Improvement

People living there could not be sure the staff caring for them had received appropriate training, professional development and supervision to meet their needs.

Care plan assessments did not always reflect a person-centred strategy and changes in assessment to help ensure that people received care that met their needs.

People's rights were protected because the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards were followed when decisions were made on their behalf.

People had a choice of meals, drinks and snacks. People who needed additional support to eat and drink received this help in a patient and kind way.

Is the service caring?
This service was caring.

Good

People told us that they were being well cared for and we saw that the staff were respectful, friendly and treated people in a kind way.

The staff took appropriate action to protect people's dignity and privacy and took time to speak with people and gave them the time to express themselves.

Staff demonstrated good knowledge about the people they were supporting and their likes and dislikes.

Is the service responsive?
The service was responsive.

Good

Summary of findings

People made choices about their daily lives in the home and were provided with a range of organised activities if they wanted to take part.

Support was provided to follow their own interests and faiths and to maintain relationships with friends and relatives and local community contact.

There was a system in place to receive and handle complaints or concerns raised

Is the service well-led?

Requires Improvement 

The service was not well-led.

This was because the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for quality assurance

The home did not have a registered manager in post.

The provider had formal and informal systems to gather the views of people who used the service.

Kendal Care Home

Detailed findings

Background to this inspection

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

This inspection took place over three days on 8th, 9th and 12th February 2015 and was unannounced. The inspection was carried out by two adult social care lead inspectors, a pharmacist inspector, a specialist advisor for mental health 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.

The inspection included a night visit to monitor staff levels, speak with night staff and the people living there and ask them about their experiences.

Before the inspection visit we gathered information from a number of sources and reviewed the information we held about the service. We looked at the information received about the service and from concerns and complaints that had been raised with us about the service. We contacted local commissioners of the service, the Clinical Commissioning Group (CCG) and health and social care professionals who were familiar with and/or visited the home to ask their opinions about the care and support provided.

We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals and applications the manager had made under deprivation of liberty safeguards.

During the visit we spoke with 26 people who lived in Kendal Care Home in private and also within communal areas as we went around the home. We were able to speak with 14 people who were visiting the home on the days of the inspection. We spoke with 17 staff during the inspection. This included nursing staff and care staff, the suite managers, domestic, maintenance and activity staff. We spent time with the deputy manager who was in charge of the home until a new manager was in post and the home's administrator. During the inspection we spoke with visiting nursing and medical professionals.

We looked at the care and support plans for 12 of the people who lived in Kendal Care Home to help us track how their care was being planned and delivered. We examined staff rosters for all the suites over the last three months, the home's training plan, staff recruitment files and the quality monitoring and assurance systems in use. We spent time on all the suites observing people living there and staff as they went about their day.

The pharmacy inspector carried out a detailed inspection of medicine management, storage, administration and disposal. As part of the inspection we also looked at records, medicines and care plans relating to the use of medicines.

Requires Improvement

Is the service safe?

Our findings

At our inspection of this service on 13 October 2014 we found that people were not protected against the risks associated with medicines because the registered provider did not have appropriate arrangements in place to manage them safely. During this inspection, 8th, 9th and 12th February 2015, we checked the provider's progress towards making improvements in medicines management. We found that the registered provider had significantly improved the way medicines were handled to help ensure the safety of the people living there. New arrangements were in place to manage medicines for people coming to live in the home to ensure a continuous supply. Staff who administered medicines had been assessed as competent to administer medicines.

Medicines were being kept and administered safely and storage was clean, tidy and secure so that medicines were fit for use. We found that arrangements had been introduced to help ensure that medicines that needed to be given before meals were given correctly. Arrangements were also in place to reduce the length of medicines rounds so that medicines were given at the right time and not unnecessarily delayed. We observed a nurse preparing and giving medicines to residents and found that this was done carefully, patiently and knowledgeably. We checked a sample of eight medicines liable to misuse called Controlled Drugs and records tallied with the quantity in stock.

All of the people we spoke with who lived in the home told us that they felt safe. They felt that the home was physically safe with all its fixtures and fittings in good order and with "very good" security on the doors.

Everyone we spoke with told us that the call system in their rooms worked well and they "mostly" received a prompt response from the staff on duty. We noted that call bells rang frequently but there was enough care staff available to answer the bells.

Two people did tell us when the staff were busy, such as at meal times, the response times could be a bit longer but they understood the reason why. We spent time on all the suites and in all areas we saw that there were nursing and care staff available to support people with personal and nursing care. One person told us, "There always seems to be enough staff. I never have to wait very long when I require assistance".

We had visited on day and night shifts to monitor staffing and skill mix levels during the day and night. There were people up watching television, having hot drinks and sitting in communal areas. They told us that they went to bed when they wanted and could have supper if they wanted it. On the night we visited there were agency staff on all the suites but they did not work without permanent staff and all we spoke with were familiar with the people they were looking after having been working there for several months. One person told us "They're all good staff, seems enough of them, even the men [male care staff] are lovely".

Staff we spoke with felt that the agency staff had made a "big difference" and "Staff isn't as much of the big problem it was and that's down to using agency". A member of nursing staff we spoke with said that it had "Taken a while to build up the team, but things are going really well now". Staff told us that only taking one admission per week on each suite was "Much better and allows the carers to get to know each resident properly". They told us that morale amongst staff had improved.

We spoke with visiting nursing and medical professionals who told us that the nursing and care staff were "helpful" but that at busy morning periods there may not be a staff member to assist them. From checking rotas we found the registered provider had responded to the instability within the staff team in the service to cover sickness, absences, vacancies and emergencies. However the rotas were not always clear and did not provide clarity who was on duty and in what capacity they were working.

We saw that the registered provider had put contingency plans into operation using agency staff to help maintain the staff establishment and be sure there was the right mixture of skills and knowledge. This had been intended as an interim measure in response to losing staff and being unable to recruit staff locally but these measures were still in place and may not be safely sustainable over the long term.

The registered provider had systems in place to make sure people living there were protected from abuse and avoidable harm. Staff told us they had received training in safeguarding adults. We saw information on all the suites

Requires Improvement

Is the service safe?

on what to do if anyone suspected someone was being abused in some way or at risk of abuse. This meant staff and people using or visiting the service had information so they could act themselves.

The nursing and care staff, both permanent and agency, we spoke with could tell us of what may constitute abuse and how to report it. They told us they would tell the suite manager in the first instance and knew they could report allegations to social services if they felt action had not been taken. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. The deputy manager had kept CQC informed about any referrals made to the Local Authority safeguarding team.

We saw during lunch on the unit where people living with dementia lived that one person in the dining room became agitated and distressed. This had the effect of unsettling other people having lunch. We saw that this was quickly dealt using distraction techniques and extra staff coming into the dining room to assist and calm other people. Staff told us they did not use restraint and that they knew people well enough and what strategies were in place to support their behaviours.

We looked at the staff files of eight people working there, three of whom had started work since our last inspection.

The staff recruitment files showed that a Disclosure and Barring Service (DBS) check had also been completed before they had started working in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This check helped to make sure that the right people were employed for caring work by the service.

We looked around the home and saw that all areas were clean and fresh. There were procedures in place about keeping the equipment in use clean and domestic cleaning records were also being kept. There was information and procedural guidance for care staff on hand washing and good hand hygiene and information on this was displayed throughout the home. There were supplies of personal protective clothing for staff to use to minimise the risks of the spread of infection. There were hand washing facilities including liquid soap and paper towels which enabled people who lived at the home and staff to maintain hand hygiene and reduce the risks of cross infection.

We recommend that the registered provider looks at more ways to attract and recruit suitable staff to permanent roles so that a stable and skilled workforce can be maintained and developed to support the wellbeing of the people living there.

Requires Improvement

Is the service effective?

Our findings

Some people who lived at the home were not able to make important decisions about their care due to living with dementia or mental health needs. We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated an awareness of the codes of practice. However training records indicated that the majority of the care staff had not had training on the MCA and DoLS and only one of the registered nurses was recorded as having done so.

The records that we saw indicated that other areas of staff training were not up to date or organised for renewal, although this need had been identified. This included Fire Safety, Safeguarding Adults, Health and Safety and also Infection Control. Records did not provide evidence that staff had completed training that was relevant to their roles and duties in the home. For example, dementia awareness training so staff had the skills and knowledge to support people living with dementia effectively or how to manage behaviours that may challenge the service. Some care staff had not completed the Common Induction standards in preparation for their roles.

Agency staff told us that they were "familiar" with the service and its procedures having been working there for some months. They told us that they moved around the home and had got to know the different suites over time. An agency staff member told us that they had not read the service's policies and procedures but "Had gone straight into the job". They explained that on days there were permanent staff to offer support. However they expressed concern that agency night staff may not have that level of support as there were less to permanent staff to support them.

We were told by agency staff that they had their own training with the agency and did not have training or supervision from the registered provider. We were told by agency staff that "The home's staff have their own training programme; we have nothing to do with that". Many agency staff had been working at the service for several months but there was no evidence that they received formal supervision of their practice or the opportunity to update their training and development to make sure they still had the skills to meet people's nursing and personal needs. This meant that the registered provider could not make sure that all the staff working there had received all the training and support they required and that was relevant to their roles.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people living there could not be sure the staff caring for them had received appropriate training, professional development and supervision to meet their needs.

People we spoke with who lived in the home told us that they made decisions about their daily lives in the home and said the staff supporting them respected the choices they made. We were told, "The staff do their best to see to my needs".

We looked at the assessments for people who had 'just in case' medicines for palliative care prescribed. These care assessments had not been updated to provide a person-centred strategy to ensure appropriate support and use of medicines during end of life care. This meant that the planning and review of individual's care could be inconsistent as some information did not get updated.

The care plans we looked at in detail had all been reviewed every month but there was no evidence that people or their representatives had been consulted or contributed to the review process. People we spoke with were unsure of what their care plans involved. We were told, "They must have what I need written down somewhere".

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plan assessments did not always reflect a person-centred strategy to help ensure that people received care that met their assessed needs.

We spoke with visiting nursing and medical professionals who told us that the level of requests for medical visits for the people living there was, in their view, at a high level. We were told that there were times when nursing staff requested medical visits when they should have the nursing skills and competence to deal with the medical issue in question. They gave us examples of occasions when they had found this.

Requires Improvement

Is the service effective?

Information we also had from the Clinical Commissioning Group (CCG) indicated that the home did also have a high level of non-elective [emergency] hospital admissions. The information we had indicated to us that the registered provider may need to review the clinical skills levels of nursing staff to make sure they had the right skills to respond themselves to people's nursing needs and management.

We discussed this with the deputy manager. The deputy was already aware that there was a need to support and help develop some staff to be more confident in practice. They showed us how this would be done to help ensure that all permanent nursing staff working in the home had the right skills needed to carry out their roles safely and confidently.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We saw from records that potential restrictions on people's liberty had been raised with the managing authority to make sure the service was acting in line with the legislation.

We looked at care plans on the units to see how decisions had been made around the treatment choices people had made and specifically 'do not attempt cardio pulmonary resuscitation' (DNACPR). We saw that people who had capacity to make decisions about their care and treatment had been supported to do so. Best Interests discussions had also been documented in the person's file. The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were used when assessing an individual's ability to make a particular decision.

We spent time on all the units at meal times and saw that staff spent time with people making sure they had eaten. People who needed assistance to eat were helped to do so and staff sat with them offering encouragement and reassurance. We saw that other staff were also eating their own meals with the people in the dining room which indicated a sense of community. People told us about the food on offer and said, "The food is good, there is a good variety and you get a good choice." And also "If I don't like what is on offer they do me something else. I can't fault it."

We spoke with the chef who showed us the information sheets that he had listing everyone's dietary needs. The chef told us how he used these to insure that all the residents were provided with a meal appropriate to their needs. The chef was in the process of providing menus in a pictorial format to show what the meals offered looked like to help people to select what they would like to eat. There were also themed menus that linked to activities in the home. One person told us about this, "Sometimes they have a day with special food I don't like [Greek week], but there is always an alternative."

All of the care plans we looked at contained a nutritional assessment and a regular check on people's weight for changes. We saw that if someone found it difficult to eat or swallow advice was sought from the dietician or the speech and language therapist (SALT). Where the home had concerns about a person's nutrition they had involved appropriate professionals to help make sure people received the correct diet. When asked staff were able to tell us which people had any special dietary requirements and we saw that where these were recommended, for example a soft diet, these were provided appropriately.

We found that there were records of communications with people's GPs, specialist nurses and community mental health teams so that changes to treatment and medication were clear. We could see in people's care plans that the service worked with other health care professionals and support agencies and social services to help meet their physical and mental health needs.

Good

Is the service caring?

Our findings

The people who lived Kendal Care Home that we spoke with told us they were satisfied with the care and support they received. The people we spoke with on the nursing unit all felt that they were treated with respect, and saw the staff as friends. We were also told "I am generally very satisfied" and "The staff are very friendly and look after me well at night". All those we spoke with confirmed they felt comfortable in the home. One person said, "The meals are lovely' and "I get very well looked after – like the Queen!'.

At the meal times we observed people were able to remain at the tables as long as they liked and were offered another hot drink. Other people had chosen to have their meal in their rooms and this was respected. We saw that staff offered people snacks and drinks throughout the day and a trolley was taken round to anyone in their rooms so they could see the choice of things they could have.

We spoke with visiting relatives of the people living there who told us that the staff were "All very good" and "Know what [my relative] needs". They also said that the staff team were "A good team" and "listen". The relatives we spoke to told us that they were "satisfied" and "pleased" with the care at the home and one told us that "I think it's brilliant here." They also confirmed that they could visit when it suited their relative and there were no restrictions on when they could be with them.

The staff we spoke to and observed talking to the people living there responded to people in a compassionate manner. Throughout our inspection we saw that the staff gave people the time they needed to communicate their wishes. The staff spoken with showed a good knowledge of people's care needs and individual preferences. We saw that care staff were able to engage well with people and talk about topics they knew they were interested in. We saw that people who could not easily speak with us were comfortable and relaxed with the staff helping them.

Where people were living with dementia there was highly visible signage to show people what different areas were for. This highly visible signage was to help people with memory problems to be able to move around their home more easily and more independently. This was in line with accepted good practice to help people living with dementia retain their independence and help ensure inclusive access for everyone in the home.

Some people used items of equipment to maintain their independence. We saw that the staff knew which people needed pieces of equipment to support their independence and provided these when they were needed. This included providing people with their walking frames and seat cushions to relieve pressure when sitting as well as adapted cutlery to help people eat their meals independently.

In addition to the main communal areas there were also extra relaxing quiet rooms to be used by people and their families for privacy. There was also a 'gentleman's club' area which had been well decorated and it was evident that much thought had gone into the designing and decorating of these rooms.

We also observed care staff knocking before they entered resident's rooms and ensuring they maintained the privacy and dignity of the residents. We saw that bedroom doors were always kept closed when people were being supported with personal care. People we spoke with told us that they saw their doctors in their own room when they visited.

Throughout the time we spent in the home we saw that people had free access to their own rooms at any time and some people chose to spend part of the day in their own rooms. All bedrooms at the home were used for single occupancy so people were able to spend time in private if they wished to. All the bedrooms had en suite toilet and shower facilities so people had privacy for personal care needs.

We saw that people had the opportunity to make decisions about future care, treatment and their wishes should their health needs change radically and this was recorded in their plans. People also had a brief end of life care plan.

We found that a range of information was available for people in the home to inform and support their choices. This included information about the providers, the services offered and about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes. We were able to see examples of when the 'Age Concern' advocacy service had been used to support individuals.

Good

Is the service responsive?

Our findings

The people we spoke with who lived there told us that they felt that the staff knew them well enough as individuals to be aware of what their needs and preference were. They told us that all the staff asked them what they wanted doing. We were told, “The staff ask me what I want to wear or what activity I would like to join in with".

All the people living there that we spoke with were felt that their care was focussed on their individual needs. Their reasoning was that the personal relationship they had with the care staff ensured this. We were told “The girls [staff] ask me how I am and then get me what I need.” And also “If I am not feeling well they keep checking up to see how I am.” One person told us that the staff had “Got help in quickly” when it was needed.

Care plans showed that assessments had been done to identify people’s care and support needs. We looked at care plans for ten people across the three units and saw that these had been subject to reviews.

We found that care plans relating to medicines were much improved since our previous inspection. For example, we saw that one care plan relating to the use of a powder for thickening drinks was updated promptly following a national safety alert on the use of these products

We could see that people’s families had been involved in gathering background information and life stories about people to help inform the care plans for staff. Relatives also told us that they had the opportunity to take part in helping to develop life histories and comment on their relative’s social and cultural preferences. Information on people’s preferred social, recreational and religious preferences were recorded in individual care plans. This helped to give staff a more complete picture of the individuals they were supporting.

We saw that a range of organised activities were available for people to participate in if they wished. The home had three activities coordinators and the activities plan was displayed for people to refer to. During our inspection we saw these planned activities taking place. Some people were going out to visit Carnforth station, where the film ‘Brief Encounter’ had been filmed and there was also an exercise session in one of the lounges.

Relatives told us that the activities had "got better recently’. There was now a new activities coordinator working with people who were living with dementia. The coordinator was busy putting together ‘memory boxes’ for people that could be used to provide stimulus for reminiscence and individual activities. Memory boxes are compiled to capture memories and stories about a person's life. It can help open up communication channels between someone living with dementia and those caring for them.

We were told by people, and we saw from the records, that people were able to follow their own beliefs. There were monthly multi denominational religious services and also prayer services for people to take part in if they wanted.

The service had a complaints procedure that was on display in the home for people living there and visitors to refer to. People living there and relatives told us they knew they could make a complaint and that they knew there was a complaints procedure. The people living there we spoke with said they felt any complaint would be dealt with by the staff.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post as required by their registration with the CQC. The registered manager had resigned and was on leave during their notice period that would be complete by the end of March 2015. They had applied to CQC to deregister as manager.

The service has had three registered managers since it was registered in June 2013. The registered provider told us that they had already recruited a new manager for the post who would need to apply for registration with CQC when they took up the post. The home's deputy manager was acting as temporary manager during our inspection. Staff we spoke with told us that that the Deputy Manager was "supportive" and "approachable". They also that "Things are very different now" and that there had been "Lots of staff changes during the past year" but that "Things were now progressing".

The registered provider had a system in place for the registered manager to monitor and report back to them on quality monitoring issues and assurance monthly. This required the registered manager to carrying out audits and send the findings of their checks to the provider as part of a larger organisational quality monitoring system. We could see that this was being done to good effect with the monitoring of equipment, premises maintenance and cleaning. However we could see the system had not been used as effectively when monitoring, care plans, training and induction for staff to make sure all training staff needed to carry out their roles had been done.

Care plans were not routinely quality monitored, we saw that the depth of information in care plans relating to the support people needed to receive medicines and treatment varied. There was some inconsistency in how care plans had been reviewed and updated. Some were good, we found others were lacking in detail and had not been updated for example, to ensure appropriate use of medicines during end of life care.

We could not assess how complaints raised had been dealt appropriately and if lessons had been learned from them as the complaints log and records could not be found. The same applied to checks that had been made on nurse's registrations as the previous manager had maintained this information. We could not see how these matters were being currently monitored.

These examples indicated to us a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effective operation and quality assurance.

Staff told us that they had staff meetings to discuss matters and promote communication about what was going on. We saw that there were daily department head meetings to look at any changing care needs or staff issues. There were also meetings held for the people living there and their families to attend to give feedback and make suggestions. These kind of meetings and using quality surveys helped communication within the home for those living and working there.

We looked at the records of accidents and incidents that had occurred in the home on the units. We did this to check if action had been taken promptly to analyse any incidents and take action to reduce the risk of it happening again. We saw that incidents had been recorded and followed up formally with appropriate agencies or individuals where needed. For example a medicines error had occurred the day before the inspection. We found that this was managed appropriately with the necessary incident reporting, investigation and actions to reduce the risk of recurrence. An incident form had been completed, family informed, safeguarding agencies had been notified and an investigation was being done.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Evidence was not available that all staff in the home had received appropriate training, induction and support for their roles. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care plan assessments did not always reflect a person-centred strategy and changes in assessment to help ensure that people received care that met their needs. Regulation 9 (1) (c) and (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: How the regulation was not being met: People were not being protected against the risk of unsafe care because the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness. Regulation 17 (2) (a), (d).