

Cotswold Spa Retirement Hotels Limited

Dolphin View Care Home

Inspection report

Harbour Road
Amble
Morpeth
Northumberland
NE65 0AP

Tel: 01665713339
Website: www.fshc.co.uk






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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This inspection took place on 8 August 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Dolphin View Care Home provides care and accommodation for up to 42 people, some of whom have nursing care needs and/or dementia. On the day of our inspection there were 33 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

Dolphin View Care Home was last inspected by CQC in June 2015 and was rated Good overall.

At this inspection, we identified issues with the management of medicines. For example, we found some gaps in the daily recording of medicines storage temperatures, some medicines that were time specific had not been administered at the appropriate time, advice had not been sought from the pharmacist regarding the crushing of a medicine, important information regarding 'as required' medicines had not been documented, medication administration records had not been consistently signed, and no records were kept for one person to show when and where topical medicines were to be applied.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks.

The manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

The home was clean, spacious and suitable for the people who used the service. Appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and training was arranged for any due or overdue refresher training. Staff received regular supervisions and appraisals.

The provider applied the Mental Capacity Act 2005 (MCA), including Deprivation of Liberty Safeguards (DoLS), in line with legal requirements and their responsibilities. However, some mental capacity assessments and specific decisions were not always fully recorded. People and family members told us they were involved in planning their care and had given consent, however, records did not include evidence of

this consent being given. We have made a recommendation about this.

People's dietary needs were catered for and people were offered a choice at meal times.

Care records contained evidence of people being supported during visits to and from external healthcare specialists.

People who used the service and family members were complimentary about the standard of care they received at Dolphin View Care Home. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

End of life care plans were in place for people as required, however, some records lacked specific information regarding people's individual wishes.

Care records showed that people's needs were assessed before they started using the service and records were written in a person centred way.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint. There had been not been any formal complaints recorded at the service for over two years.

The provider had a quality assurance process in place, however, this had not identified the issues with medicines and consent highlighted in this report.

Staff said they felt supported by the manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys. Family members told us the management were approachable and accommodating.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 12, entitled Safe care and treatment and Regulation 17, entitled Good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

People were not protected against the risks associated with the unsafe use and management of medicines.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated. Risk assessments for people and staff were in place with control measures to follow, to protect them from harm.

The manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

Is the service effective?

Good 

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs.

The provider was following the requirements in the Deprivation of Liberty Safeguards (DoLS).

People and family members told us they were involved in planning their care and had provided consent. However, records did not include evidence of this consent being given.

People had access to healthcare services and received ongoing healthcare support.

Is the service caring?

Good 

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

Is the service responsive?

Good ●

The service was responsive.

People's needs were assessed before they started using the service.

Care records were person centred and reflected people's changing needs.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The provider had a quality assurance system in place and gathered information about the quality of their service from a variety of sources. However, the quality assurance system had failed to identify the issues with medicines and consent highlighted in this report.

The service had a positive culture that was person-centred, open and inclusive.

Staff told us the manager was approachable and they felt supported in their role.

The service had good links with the local community.

Dolphin View 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 on 8 August 2017 and was unannounced. This meant the staff and provider did not know we would be visiting. One adult social care inspector and a specialist advisor in nursing carried out this inspection.

Before we visited the service we checked the information we held about this service and the provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

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 used this information to inform our inspection.

During our inspection we spoke with four people who used the service and seven family members. We also spoke with the registered manager, regional manager and four members of staff.

We looked at three care records and nine medication records for people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We carried out observations of staff and their interactions with people who used the service. 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 may not be able to talk with us.

Is the service safe?

Our findings

We looked at the arrangements for the management of medicines and found that people were not protected against the risks associated with the unsafe use and management of medicines.

Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Medicines which required cool storage were stored in a refrigerator in the treatment room. We found there were some gaps in the daily recording of temperatures. Best practice guidance states that refrigerator and treatment room temperatures should be recorded to make sure medicines are stored within the recommended temperature ranges. We discussed this with the manager who told us they were going to change the responsibility of recording temperatures to the day shift nurses as the gaps had occurred when agency staff had been on night shift.

We looked at the administration of people's medicines to check whether it was safe, and protected and promoted people's health and wellbeing. Medicines were given from the container they were supplied in and we observed staff explain to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken. However, we found some medicines that were time specific had not been administered at the appropriate time in terms of drug and food interactions. For example, a medicine to be given at 9am and 30-60 minutes before food had been administered at 8am. For another person's medicine that was time specific, there was no guidance on the medication administration record (MAR) to state it must be taken at least 30 minutes before the first food, beverage, or medicinal product of the day with a full glass of plain water. We discussed this with the manager who told us they would seek the advice of the pharmacist.

One person's medicine was crushed and administered to them via a feeding tube. We checked whether advice had been sought from the pharmacist since the administration involved altering the medicine's licensed presentation, however, staff were unable to provide any evidence of this. The provider's medication policy stated, "If medication is to be crushed or its form altered, this must be guided by pharmacist instruction." We discussed this with the manager who told us they would seek the advice of the pharmacist.

We looked at the management of medicines prescribed to be administered 'when required'. Although there was some information about such medicines in people's care records, this was not up to date and important information was missing. For example, some people were prescribed medicines for anxiety and there were no care plans or guidance in place to assist staff in their decision-making about when people may need to be offered these medicines in line with behaviours that they may display. This lack of information meant there was a risk that people may not receive the medicines they required at the times they needed them.

Medication administration records (MAR) contained recent photographs of people to reduce the risk of

medicines being given to the wrong person and all the records we checked clearly stated if the person had any allergies. This reduced the chance of someone receiving a medicine they were allergic to. The majority of the MARs we looked at were signed and up to date, however, we identified three gaps in signatures to evidence administration of medicines in one record and one gap in another record. This meant MARs had not been consistently signed and we could not be assured that care staff had given people their medicines as prescribed.

We looked at the records for two people who had topical medicine creams applied by care staff. Topical medicines are applied externally to the body's surfaces. There were no records kept for one person to show when and where the topical medicines were to be applied, and the application of this medicine was not signed for on the MAR. This meant we could not be sure that people received their medicines as prescribed.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and their family members told us Dolphin View Care Home was a safe place to live. They told us, "Very safe", "Oh yes, he's safe" and "Everything's ok. He's safe."

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. 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 helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates.

We saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. The manager carried out monthly checks of the registration status for all the nurses working at the home to ensure they were registered with the Nursing and Midwifery Council (NMC). This meant the provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff, and on an ongoing basis as necessary.

We looked at staff rotas and discussed staffing levels with the manager. The manager told us staff absences were covered by the home's permanent staff, however, agency nursing staff were used to cover some absences at night. Staff we spoke with did not raise any concerns about staffing levels. A person who used the service told us, "No concerns about the staff. They always come when I call." Our observations showed that call bells were answered in a timely fashion and there were sufficient numbers of staff on duty to meet the needs of the people who used the service.

An effective system was in place for recording accidents and incidents. These were recorded electronically and regularly viewed by senior management to ensure appropriate action had been taken. Risk assessments were in place for people who used the service and staff and described potential risks and the safeguards in place. These included the use of equipment, first aid, moving and handling, and fire. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Risks to people's safety in the event of a fire had been identified and managed. For example, a fire risk assessment was in place, fire drills took place regularly and fire-fighting equipment checks were up to date. A fire alarm test was carried out during our visit. Personal Emergency Evacuation Plans (PEEPs) were in

place for people who used the service which contained information about how to support them to be transferred within, or evacuated from the building in an emergency.

The home is a two storey building in its own grounds. Entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. Appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. This meant people were protected from the risk of acquired infections.

Equipment was in place to meet people's needs including hoists, pressure mattresses and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Window restrictor checks were carried out, and Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). This meant that checks were carried out to ensure that people who used the service were in a safe environment.

Copies of the provider's and local authority's safeguarding policies and procedures were available in the foyer. Safeguarding related incidents were appropriately recorded and CQC was notified of any relevant incidents. The manager understood their responsibility with regard to safeguarding and staff received training in the protection of vulnerable adults.

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People and their family members told us, "I like it here. I'm surprised how quickly I've settled", "Yes, very well looked after", "It's very nice" and "Oh he's well cared for."

Staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely. This included moving and handling, management of medicines, infection prevention and control, first aid, fire safety, dementia awareness, safeguarding, food safety, health and safety, mental capacity, and nutrition. The manager monitored training via the provider's electronic training matrix and sent reminders to staff via email when training was due. This was also monitored via the regional manager on a weekly basis to ensure staff training was up to date.

New staff completed an induction, which included an introduction to the home, policies and procedures, health and safety, and mandatory training. All new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff told us they received regular supervisions and appraisals and felt supported in their role.

For people at risk of malnutrition, assessments had been carried out using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. For people with a MUST score of one or two, the MUST states the person should have a food and drink plan implemented, together with being weighed on a weekly basis. Records showed people were being weighed monthly rather than weekly. We discussed this with the manager, who acknowledged people should be weighed as per the MUST guidance and they would implement this immediately. We saw that guidance had been sought from a dietitian and speech and language therapist (SALT) when required and this was documented in the care records.

We saw that some people required thickening agents to be added to foods and liquids to bring them to the right consistency or texture so they can be safely swallowed by people at risk of choking.

We saw the kitchen staff had been informed of people's food likes, dislikes and dietary needs in a pictorial format. This meant there was good communication between care and catering staff to support people's nutritional well-being.

We observed lunch and saw people were brought to the dining room shortly before lunch was served. Staff wore appropriate PPE and aprons were offered to those people who wanted or needed them to protect their clothing. Staff assisted people who needed support with their meals. This was done in an unhurried manner

and staff prompted people as required. Some people preferred to eat in their own bedrooms and food was delivered to them on a tray.

A choice of food was available and people were offered a drink with their meal. Verbal interactions between staff and people were positive and friendly, and staff demonstrated a good understanding of people's individual needs. For example, knowing whether a person was required a soft diet, and what people's food preferences were. A staff member told us, "It's nice when everyone comes into the dining room. They have a chat and it's a nice atmosphere."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care 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. The manager maintained a DoLS register, which recorded when an application had been submitted, when it was authorised, and when it was due to expire. Notifications of the applications had been submitted to CQC. This meant the provider was following the requirements in the DoLS.

People's ability to make complex decisions were recorded. For example, "Requires assistance from their family for all complex decisions" and "Person has relative to assist with their choices and help with complex decisions that person cannot make themselves." However, some specific mental capacity assessments and best interest decisions were not fully recorded. For example, one person's assessment for bed rails and bumpers was not fully completed as there were no details of the person completing the form or details of the other people involved in the assessment. People and family members we spoke with told us they were involved in care planning and had provided consent for care and treatment, however, this was not consistently documented in the care records. For example one consent to care and treatment record stated, "Verbal discussion with [family member]" but the other records we viewed were blank.

We recommend the provider revisits their recording systems to appropriately reflect where people or family members have provided consent to care and treatment.

Communication care plans were in place and were appropriate for the person. We saw information for staff to follow in relation to how they engaged with people. People had emergency health care plans (EHCP) in place. An EHCP makes communication easier in the event of a healthcare emergency, for example, if a person needs to go into hospital.

People's care records showed details of appointments with, and visits by, health and social care professionals. For example, GPs, psychiatrists, community nurses, tissue viability nurses, specialist nurses, social workers and chiropodists. Care plans reflected the advice and guidance provided by these professionals. One of the people we spoke with was visiting the hospital to have their hearing checked during the afternoon of our visit.

Some of the people who used the service were living with dementia. We looked at the design of the home for people with dementia and found the service incorporated some environmental aspects that were dementia friendly. For example, dementia friendly signage was in place, communal rooms and facilities were clearly signed, and corridors were wide and bright to aid orientation around the home.

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Dolphin View Care Home. They told us, "The staff are lovely" and "Very caring."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way. For example we observed a member of staff approach a person in the corridor. They asked, "Shall I take you back to your room?" The person said yes, so the staff member gently took the person's arm and guided them back to their bedroom. They then told them, "Tea and cakes will be coming around soon."

We saw staff knocking before entering people's rooms and closing bedroom and toilet doors before delivering personal care. We asked people and family members whether staff respected the privacy and dignity of people who used the service. They told us, "Yes absolutely" and "They always close the door."

The manager told us, and records confirmed, that all the staff were trained in dignity and person centred care. The dignity noticeboard in the home described what dignity was and provided a guide on what "dignity means to you." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People were supported to remain independent. This was evident at lunch time when we saw people eating and drinking independently but staff were on hand in case they needed assistance. People had 'One page profile' records that described what was important to them. For some people, this was maintaining their independence. For example, one person's profile stated, "Going out on my own to keep my independence" was important to them. This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

Bedrooms were individualised, some with people's own furniture and personal possessions. We saw photographs of relatives and social occasions in people's bedrooms and in memory boxes outside people's bedroom doors. We saw lots of visitors to the home and all the people we spoke with told us they could have visitors whenever they wished. The family members we spoke with told us they could visit at any time and were always made welcome.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The manager told us none of the people using the service at the time of our inspection visit had advocates, however, information on advocacy services was available in the foyer.

End of life care plans were in place for some people but were not always fully completed. One end of life care plan we looked at simply stated, "Discussed with family" but contained no further information. We discussed this with the manager who agreed to review the records.

Is the service responsive?

Our findings

Care records contained a pre-admission assessment to assess people's needs before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure the person's safety and comfort.

Dependency assessments were carried out for people. This ensured there was a summary of the care requirements of people living at the home, to ensure that staff had the capacity and skills to be able to provide appropriate care to meet people's needs.

Following an initial assessment, care plans were developed detailing the person's care needs to ensure personalised care was provided to all people. People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Care plans were reviewed monthly and on a more regular basis, in line with any changing needs, and were reflective of the care being given and any changes in people's needs or care.

The care planning process included the completion of risk assessments, which included an assessment of the level of risk and action that needed to be taken to mitigate the risks to the health, safety and welfare of people, and keep people safe. Risk assessments included moving and handling, mobility, falls, nutrition and hydration, choking, continence and skin integrity. The provider used recognised risk assessment tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) to complete individual risk assessments, which helped identify the level of risk and appropriate preventative measures.

Some of the people in receipt of care from the service were at varying risk of developing pressure ulceration. Assessments had been carried out to identify which people were at risk of developing pressure ulcers and preventative pressure relieving measures were in place for those people who required them. People had care plans to inform staff of the intervention they required to ensure healthy skin. Care plans evidenced access to the tissue viability nurse to assess people's skin condition and provide specialist support on what was needed in terms of care and pressure relieving equipment to minimise the risk. Although one person's wound care plan had not been updated since May 2017, all the other records we saw were up to date. The manager told us they would review the record.

We looked at the care records for one of the people who was being fed via a percutaneous endoscopic gastrostomy (PEG) tube. A PEG is a procedure where a feeding tube is placed through the skin and into the stomach to enable care givers to deliver to people, the nutrients and fluids they need, when they are not able to eat or drink via their mouth. The care plan detailed the feeding regime, how to carry out water flushes and weight monitoring. A separate file was kept in the nurses' office that provided guidance on what to do if anything went wrong with the PEG, including contact details for the PEG nurse specialists. The PEG nurse specialists had trained the staff in the use of the PEG and visited the home every two months.

Records confirmed the level of support people required to maintain personal hygiene. People's mobility

needs were identified and specific plans for supporting people with their mobility needs and transfers were in place and regularly reviewed.

Daily notes were kept for each person, which were concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition.

Care records contained a social profile for each person. These included details about the person's preferences, interests, people who were significant to them, spirituality and their previous lifestyle. For example, "Enjoys looking at their family book, which is full of family photos" and "Likes to watch TV, enjoys family visits."

The weekly activities planner described what activities and events were available to people at the home. These included crafts, clay modelling, one to one sessions, hairdressing and beauty therapy, pet therapy, tea parties, church services and visits to local events and attractions such as a monthly dance at a local club and Alnwick Gardens.

We spoke with the activities coordinator who told us they had a chat with each of the people who used the service on a Monday morning to find out what they wanted to do. This was used to plan the week ahead, including one to one sessions for people who were unable or didn't want to join in group sessions. The activities coordinator told us money raised from fairs and events was used to fund external activities or hire visiting entertainers. They told us how they had involved people in planning their own wedding, including the design of the cake, flowers and wedding dress, and had visited the home on the day of the wedding so people could see their dress.

We asked people if there was much to do at the home. They told us, "Plenty to do", "I have friends downstairs. I go and see them" and "There's lots going on." This meant the provider protected people from social isolation.

The provider's complaints procedure was on display in the foyer. This described the procedure for making a complaint and the timescales for receiving a response to the complaint. The manager showed us the complaints file. There had not been any formal complaints recorded at the service since 2015, however, we saw blank copies of complaints monthly records that the manager would use to monitor complaints should they arise. People we spoke with, and their family members, were aware of how to make a complaint, but they did not raise any concerns or complaints with us during the inspection. This showed the provider had an effective complaints policy and procedure in place.

Is the service well-led?

Our findings

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The manager conducted a number of monthly audits that were recorded electronically and reviewed by the regional manager. These included audits related to information governance, housekeeping, health and safety, human resources, dining, medication, infection control, and care records. The regional manager also carried out their own monthly audit of the service and an action plan was put in place for any issues identified. Audits of care documentation were carried out for one person each week. However, there was no structured audit matrix and the care records were chosen at random.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found the manager completed daily medication audits for two people, weekly medication audits for eight people and a full monthly medication audit. However, these checks had not identified the issues with medicines highlighted in this report.

This demonstrated that the provider had a wide ranging quality assurance system in place and gathered information about the quality of their service from a variety of sources. However, the quality assurance system was not always effective as it failed to identify the shortfalls in medicines that we found during our inspection. It also failed to identify the shortfalls in records and recording around consent, about which we have made a recommendation.

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

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the manager about what was good about their service and any improvements they intended to make in the next 12 months. They told us they had an "open door policy" and "It's about supporting the whole family, not just the person in care." With regard to improvements, they told us they had recently replaced the downstairs carpets and had plans to replace the upstairs carpets next. New kitchen equipment had recently been installed and they had identified some bedrooms that required new flooring. They told us nurse recruitment was ongoing but agency nurses that were used were regular and consistent to ensure continuity of care.

The manager conducted a daily walk around of the home. This included the cleanliness of the home, the appearance and well-being of people who used the service, the completion of charts and records, and discussions with people and staff.

The manager obtained feedback on the quality of the service by asking a selection of people who used the service a series of questions. The manager told us family members were encouraged to use an electronic tablet that was available in the foyer to provide feedback on the quality of the service. If any responses were negative, these were automatically flagged to the manager and regional manager to investigate. The manager told us any issues were actioned and discussed with staff at team meetings.

A feedback board on the ground floor corridor was kept up to date by the manager with feedback from the latest surveys. This included comments made by people and family members on the quality of the service. For example, "Some days I don't like what's on the menu but they get me something different" and "I am much better off since I moved here."

The service had a positive culture that was person centred, open and inclusive. People who used the service, and their family members, told us, "We couldn't do without the girls [staff], we've become one of the family", "The girls [staff] do a super job, couldn't think of [name] anywhere else" and "It runs well, we can come and go freely." Staff we spoke with felt supported by the manager, they were comfortable raising any concerns and said that morale was good at the home. They told us, "[Manager] has been really good", "Lots of support", "All the girls [staff] help out" and "They're [manager] very fair, they do support you." The manager told us, "I have great staff. I'm proud of every one of them" and "Staff muck in."

Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings took place monthly and staff provided feedback on the quality of the service via the home's electronic tablet.

The service had good links with the local community. This included taking part in the local annual festival, summer and Christmas fayres, and the manager had visited the local harbour master to rent a beach hut so people could go out for the day and have a barbeque during nicer weather.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them ensuring people's personal information could only be viewed by those who were authorised to look at records.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The quality and safety of the service provided was not being effectively assessed or monitored. Regulation 17(2)(a).