Akari Care Limited

Crofton Court

Inspection report

Edward Street
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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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 26 November and 2 December 2015 and was unannounced. The previous routine inspection was carried out on October 2013 when all standards were met.

Crofton Court is located in the centre of Blyth it provides accommodation and personal care for up to 50 older people some of whom have dementia. People living with dementia at the home were accommodated upstairs in the Edward and Renwick units. At the time of the inspection there were 48 people using the service.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

We found shortfall in how medicines were managed and the storage of medicines. In addition, we found shortfalls in the recording of some medicines which meant it was not always possible to ascertain whether people had received their medicines as prescribed.

Summary of findings

On the second day of the inspection the registered manager told us that they had brought forward planned medicines refresher training as a result of our findings.

People told us they felt safe. There were safeguarding policies and procedures in place. Staff knew what action to take if abuse was suspected and we saw posters displaying information about safeguarding champions and whistle blowing. We had not been informed however, of certain safeguarding incidents. These involved altercations between people.

The building was clean and well maintained, there were no malodours. The overall standard of décor and furnishings was good and attention had been paid to dementia friendly design upstairs in the Edward and Renwick units.

Staff told us that there was only one moving and handling hoist for people who were unable to weight bear. We observed staff moving one person inappropriately when they became unwell because the hoist was stored downstairs.

Records of regular safety checks and inspections of the premises and equipment were available.

Visiting professionals spoke highly of the service. People had access to a range of health professionals including GP's, specialist nurses, dietitians and physiotherapists. People and their visitors told us they were very happy with the care provided but some people, staff, and visitors told us that staffing numbers appeared low at times.

There was a training programme in place. Staff told us they received regular training and we checked records of training that had been completed. Systems for supervision and appraisal were in place but some staff told us they did not receive regular supervision, and we found inconsistencies and irregularities in some of the dates of supervision records we looked at. We also found that regular supervision had not been carried out for all staff.

Safe recruitment procedures were followed. Pre-employment checks were carried out to ensure the safety of people living in the home was maintained. New staff members told us that they had completed an induction process when they came into post and said that they felt they had been given the necessary training to carry out their role.

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)

The registered manager had submitted DoLS applications to the local authority for authorisation. Mental capacity assessments had been carried out for all people living in the home but these were generic and did not always relate to specific decisions. We have made a recommendation that records evidence that care and treatment is always provided in line with the Mental Capacity Act 2005.

People told us that they were happy with the meals provided. Mealtimes were relaxed and a social occasion with appropriate support being provided to people if required. Kitchen staff were aware of special diets and people were able to share their views about the meals and menu choices at a residents food forum.

Care records contained key information including medical and social histories and included the person's likes, dislikes and preferences. Records available however, did not always assure us that people were supported to meet their nutritional and healthcare needs. This was due to gaps and omissions in record keeping. People and their relatives told us that staff were caring. Throughout the inspection staff were observed acting in a professional and friendly manner, treating people with dignity and respect.

People were supported to maintain their hobbies and interests and we received positive feedback about the activities coordinator. There had been a delay in responding to the one complaint received which the manager stated was due to a change in the area management structure. There were a number of feedback mechanisms to obtain the views from people, relatives and staff. These included meetings and surveys.

Summary of findings

We had concerns with the management of the service. Some staff said they did not feel well led by the manager. Other people and visitors told us the manager was friendly and approachable.

We identified shortfalls in the maintenance of records relating to people, staff and the management of the service. The provider's own auditing system had not highlighted this issue.

We had not been notified of some incidents of abuse between people using the service, for example, as a result of behavioural disturbance or distress. This is being followed up and we will report on any action once it is complete.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to staffing, safe care and treatment and good governance. You can see what action we told the provider to take at the back 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

Not all aspects of the service were safe.

Medicines were not managed safely. There was only one full body hoist available and we observed staff use inappropriate moving and handling techniques whilst transferring one individual when they became unwell.

People, relatives and staff told us that at times there were insufficient staff on duty. Staff told us and records confirmed that they were not able to assist people with a bath or shower regularly because of staffing levels.

People told us they felt safe. There were safeguarding procedures in place. However, we had not been notified of some safeguarding incidents which related to altercations between people.

The premises were clean and well maintained. Safety checks of the premises were carried out.

Safe recruitment procedures were followed.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

Appropriate staff training was provided. Some staff said they did not receive regular supervision. We found inconsistencies and irregularities on some of the supervision records we looked at, and some staff had not received regular supervision.

The manager had records of DoLS applications submitted and authorised by the local authority. Some of the mental capacity assessments were generic and not related to specific decisions.

Visiting professionals told us they trusted the judgement and skills of staff.

People were happy with the meals provided.

Is the service caring?

Good

The service was caring.

People and relatives informed us that staff were caring.

Interactions between people and staff were positive. Staff spoke with people respectfully. Professionals visiting the service said that staff were caring.

Summary of findings

People were provided with appropriate and sensitive care at the end of their life.

Is the service responsive?

Requires improvement

The service was not always responsive.

There were gaps in records which were important for the monitoring of people's physical and psychological well-being.

There was a complaints procedure in place. Other feedback systems were in place to obtain people's views.

People were supported to maintain their hobbies and interests and a number of activities were available.

Is the service well-led?

Requires improvement

The service was not always well led.

We found shortfalls in the maintenance of records relating to people, staff and the management of the service. Routine audits had not identified gaps and omissions in care records. There were irregularities and inconsistencies in staff supervision records.

We had not been notified about some safeguarding incidents.

Some staff did not feel well led by the manager. Other people and visitors told us the manager was friendly and approachable.

Audits, surveys, and meetings to monitor the satisfaction of people and their representatives had been carried out.

Crofton 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 was carried out by two inspectors and a specialist advisor in mental health for older people. The inspection took place on 26 November and 2 December 2015. We displayed a poster informing people that we were conducting an inspection and inviting them to share their views with us.

We spoke with ten people who lived at the service and seven visitors on the days of our inspection. We spoke with two visiting professionals during the inspection and contacted two others by phone following our visit. We spoke with a local authority safeguarding officer and a local authority contracts officer.

We spoke with the area manager, registered manager, deputy manager, seven care workers, a cook, administrator and housekeeper during our inspection.

We read ten people's care records. We looked at a variety of records which related to the management of the service such as safety and maintenance records, audits and surveys.

Prior to carrying out the inspection, we reviewed all the information we held about the home. The registered manager completed a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

We checked whether the management of medicines was safe and found shortfalls with the management of medicines on the first floor. We found that the storage of medicines was not suitable. There were four full boxes of medicines stored on the floor. In addition, topical medicines were stored on the work bench. This meant that medicines were not stored safely.

The temperature within the medicines storage room sometimes exceeded 28 degrees Celsius which is above recommended limits. We noticed that one person was prescribed emergency antibiotics in liquid form in case of an infection. This medicine was stored in a cupboard when the label stated that these antibiotics should be stored in the refrigerator. Medicines stored at the incorrect temperature can deteriorate and become ineffective. The senior care worker told us that she would order a new prescription immediately for this individual.

The quantity of medicines carried forward at the beginning of the month was not always recorded. This meant it was not possible to check whether medicines had been administered as prescribed because we did not know the amount of medicine which was in stock at the start of the month.

One person's nutritional supplement was out of stock which meant that the individual was not receiving their medicines as prescribed.

Staff sometimes used a code to state that a medicine had not been administered. However, they did not always document the reason why people had not received their medicines. In addition, there were gaps in the recording of administration of some people's medicines. This meant that it was not always possible to ascertain whether people had received their medicines as planned.

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

On the second day of the inspection, the registered manager told us that they had brought forward planned medicines refresher training as a result of our findings.

We checked equipment available at the service. One full body hoist was available between two floors. There were also two stand aid hoists available for people who could weight bear. Some staff on the first floor said that an additional full body hoist would be useful upstairs, since it was sometimes time consuming to get the hoist when needed from the ground floor. We saw that one person was moved manually by staff when they became unwell. Inappropriate moving and handling techniques were used. This lack of moving and handling equipment and subsequent unsafe practice could compromise the safety of people and staff at the home.

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

One person who lived in the home, two visitors and five staff told us there were sometimes insufficient staff on duty to meet the needs of people living in the service. One person said, "They do okay with the resources they have, the staff do their best." A staff member said, "We're not working to the standard we used to (due to staffing), people aren't turning up and I think sickness has increased. Sometimes the rota is just wrong." Another staff member said, "Staff do their best but they are vastly under staffed". A visitor said, "The main issue I have is with staffing. You can't knock the staff, they are lovely and caring, I'm not complaining, I'm concerned because they are stressed." Another visitor told us they had raised concerns about staffing at a meeting some time ago.

We checked staffing levels at the service. A staffing tool was in place which was linked to the dependency needs of people who lived at the home. This was reviewed monthly.

We examined staff rotas and found that sometimes the recommended number of staff which had been set by the provider were not always on duty. The manager explained that any shortages were due to unexpected absence and covered as soon as possible. He said, if necessary the activities coordinator, a former care assistant, and manager would provide care. However, this information was not documented on the staff rotas.

All staff assured us that people were safe, but said they felt there was a risk to the overall standard of care due to the pressure they were under. Some staff informed us that they were unable to bathe and shower people as often as they wished due to staffing levels. We did not find evidence that the needs of people were not being met, and people we

Is the service safe?

spoke with during the inspection appeared clean and well cared for. We viewed personal hygiene records for people and these did not always evidence that people had been able to have a bath or shower regularly.

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

People said that they felt safe. One person said, "I feel safe and it's lovely and clean here, that's what matters most to me." Another said, "I definitely feel safe and well looked after, the staff are nice and helpful." Safeguarding policies and procedures were in place, and staff knew what to do in the event of any concerns. Training records show that people had received training in how to safeguard vulnerable adults. One staff member said, "I would definitely know the signs of abuse and would report it to the manager or deputy straight away." Posters displayed details of the whistle blowing policy and the names of safeguarding champions in the service. One visitor said, "My relative is safe and well cared for, settled, and they get what they need." One safeguarding incident was being investigated and we will report on the outcome once complete.

Some incidents of abuse between people using the service (for example as a result of behavioural disturbance or distress) had been recorded and reported to a care manager, and appropriate support sought (for example from the challenging behaviour team). While these incidents had been responded to appropriately, we found that some of these incidents had not all been notified to us in line with legal requirements. The manager told us they were now clear about this requirement. This is being followed up and we will report on any action once it is complete.

Infection control procedures were in place, for example, staff were observed wearing gloves and aprons to serve meals. Personal protective equipment was in use when staff provided personal care to people. We found that appropriate safety checks were carried out in the kitchen which had been given a food hygiene rating of 5 following an environmental health assessment. This is the highest rating possible. We saw some bathroom pull cords had plastic covers to enable them to be cleaned.

We spoke with a housekeeper who told us that cleaning schedules were in place and that they had received training in the safe handling of cleaning products. One relative told us, "It's gone down a bit, (cleaning) little things like pulling the beds out when they hoover, or little marks on the door." During the inspection we found that the home looked clean and we passed these comments to the manager. There were no malodours.

Safety checks of the building and premises were in place, and we saw records of fire safety checks and drills, water temperature checks, gas and electrical safety tests and the maintenance and servicing of mobile equipment. A contingency plan was in place which documented the actions to be taken in the case of any emergencies. Individual emergency evacuation plans were available.

We checked staff recruitment and read the records of four staff. We found that safe recruitment procedures were followed to ensure people were protected. We noted that a Disclosure and Barring Service check had been carried out which helped ensure that staff were suitable to work with vulnerable people. New employees confirmed that checks of their suitability were fully in place before they were able to commence employment.

Accident and incidents were documented. The manager analysed these to identify if there were any trends or themes. We had been notified of serious accidents. Night staff told us that they made use of assistive technology, in the form of alarmed sensor mats at night to alert them if someone was at risk of falling.

We noted that falls risk assessments were in place and there were guidelines in place to document what action staff should take to reduce the risk of falls. However, staff were not following the provider's own procedures relating to the management of falls. One person had fallen seven times since 1 to 26 November 2015. Their care plans had not been amended to reflect the changes in the person's needs and condition. The manager expressed disappointment at our findings and said that he would ensure that care plans were updated immediately to reflect the required changes.

We recommend that falls risk assessments are reviewed and updated in line with the provider's policy relating to the prevention and management of falls.

Requires improvement

Is the service effective?

Our findings

A system of annual appraisal and staff supervision was in place. It was the policy of the provider to hold an annual appraisal and six supervision sessions per year with staff. Some staff told us they did not feel adequately supervised. One staff member said, “I don’t receive regular supervision, I have only had one since the manager started.” Another said, “I can’t remember when I had supervision, is that the same as an appraisal? I think I’ve had one.” We checked supervision records and found that most staff had received supervision earlier in the year, with the last recorded session for a number of people taking place in June 2015. We found however, some inconsistencies and irregularities regarding the dates when these sessions had been held. This meant that it was not possible to ascertain whether staff were provided with the appropriate support and that supervision sessions were carried out as planned. This was being investigated by the regional manager.

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

Staff told us that there was training available. This was confirmed by the training records we examined. For example, we saw that staff had received training in the Mental Capacity Act 2005, moving and handling, fire safety, infection prevention and control and dementia care. A staff training matrix showed high percentages of staff had attended training. Where the percentage of staff trained (for example in moving and handling) appeared slightly low, it was explained that this was due to a number of new staff being employed and we saw that a training session was booked in anticipation of them starting work in the service. Training therefore appeared well planned. A new staff member told us that they have completed an induction process when they came into post.

Many of the staff had worked at the home for a considerable period of time. Two professionals visiting the home said they felt staff were skilled and that they trusted their judgement. For example, a GP told us, “We see 18 patients here and come in once a week. Staff do just as we ask them, and if they say people are unwell we know they must be”. A specialist nurse said, “We are contacted in a timely way, staff have good knowledge and skills and I have never seen anything to concern me”.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). 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).

Best interests decisions were recorded where people had been assessed as lacking capacity. Mental Capacity assessments were generic and not related to specific decisions. The manager said that he was working on improving the quality and detail of these assessments.

We saw that a relative had signed to consent to the safekeeping of one person’s money. The individual had capacity and the manager agreed that they should therefore have signed the form instead of the family member. Where people had capacity, the manager assured us that they would be involved in all decisions about their care or finances in future. Consent forms were in use. Staff spoken to were knowledgeable about the MCA and about acting in the best interests of people. Staff told us there were designated DoLS and MCA leads for the service.

There was some attention to dementia friendly design of the premises. The seating contrasted with walls and carpets and there was a garden mural painted on the wall in the Edward unit. Some bathrooms and toilets would benefit from dementia friendly signage and design.

We checked whether people’s nutritional needs were met. Nutritional risks were assessed using a tool called the Malnutrition Universal Screening Tool (MUST). "MUST" is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese. This information was used to produce care plans to reduce these risks.The cook told us they were aware of special diets, and we saw a list of these displayed in the kitchen.

Requires improvement

Is the service effective?

People told us that they were happy with the meals at the home. Eight people had attended a winter food forum meeting in October 2015 and directly contributed to the development to the winter menu. There were regular opportunities to comment upon the quality of the food provided. People told us that they enjoyed the food in the home. We joined people for lunch and one person said to the person next to her, "We always enjoy our dinner don't we? Especially our pudding! It's always nice", the other person agreed. Another person said, "The food is really good, the meals are really nice." A relative told us, "The food is quite varied, they do listen to what they (people) say and try to include it in the menus." Another said, "When mum came in she was reluctant to eat so they bent over backwards to find things she liked."

We noted that people were supported to access a wide range of healthcare services. We observed a GP undertaking their weekly "round" in the service. Where concerns arose about the mental or physical health of people, we saw that they were referred promptly to specialist services including speech and language therapy for example or the challenging behaviour team. Visiting professionals confirmed that this was the case. Annual health checks were carried out.

We recommend that records evidence that care and treatment is always provided in line with the Mental Capacity Act 2005.

Good

Is the service caring?

Our findings

We spoke with people who told us that staff were kind and caring. One person said, “It’s lovely here, I’ve had no complaints since I came”. Another said, “The staff are nice and helpful”. We noticed that staff treated people with dignity and respect. We witnessed staff knocking on doors before entering and calling people by their preferred names.

A visitor told us, “The care is absolutely brilliant; I can’t fault the care here. My mum has been very well looked after, she has visitors every day and no matter what time of day we come she is well cared for”.

A specialist nurse told us, “The staff are really friendly and approachable, there are some really good staff.”

Staff spoke kindly to people. One person appeared tired and a staff member said, “You look a bit tired, why don’t you come and have a sit down beside me? You can keep me company”. A relative told us, “They look after the family as well. I had only been in for just over an hour this morning and three staff asked if I wanted a coffee.”

One person was distressed and upset about where she was and why. We saw staff talking to her in a sensitive way and skilfully distracted her from the thoughts that were disturbing her by involving her in some light dusting of the unit and later they were accompanied to a group activity.

The service had a dignity champion and a dignity poem was displayed on the wall. A relative told us, “The girls are excellent, and the handyman does a great job around the place”. All of the visiting professionals we spoke with commented upon the friendly and approachable manner of the manager and staff.

The people we saw appeared clean and well presented. Hair was styled nicely. One person asked for some assistance with their personal care needs and staff responded promptly and supported them discreetly and sensitively.

We read people’s care plans and saw that these were personalised. They included comprehensive pre-admission assessments with key information including medical and social histories and people’s likes, dislikes and preferences. This supported staff to care for people in the way they preferred. Care records were stored confidentially in locked cabinets to maintain privacy.

No one was accessing any form of advocacy but a procedure in place if advocacy services were required. Advocates can represent the views and wishes for people who are not able express their wishes. People in the home told us that they knew they had a social worker. One person said, “I suppose I could contact them if I needed anything but I don’t think it’s necessary.”

Support with end of life care was provided by specialist nursing staff who visited the home. Notifications informing us of the expected deaths outlined clearly that specialist support and medical care had been provided and that wherever possible family members were fully involved in decisions regarding end of life care. The wishes of people were ascertained whenever possible upon admission to the home.

Requires improvement

Is the service responsive?

Our findings

Some people and their relatives told us that staff were very responsive to their needs and we observed that detailed person centred care plans were in place. These included a comprehensive set of twelve core care plans including plans to manage complex behaviour. There were a number of care plans that reflected people's likes, dislikes and personal preferences.

We found shortfalls however, in the care files we viewed which meant it was not always possible to ascertain that staff provided a responsive service which met people's needs.

Visiting professionals from the Challenging Behaviour team told us that staff were responsive to the needs of people using the service. They said, "They know the people well, there are some lovely staff there who are skilled in supporting people." They also said that paperwork they required to support their work was not always completed, particularly more recently. This meant that it was not always possible to obtain an accurate picture of the person's needs or risks, and that information passed to them verbally by phone did not always correspond with what was written in people's records when the team visited. For example, they were told that one person had been settled and there were no concerns, but found when they visited and read the person's records that there had been a number of incidents. These were not always recorded in behaviour monitoring charts. This was confirmed by our own discussions with staff and observations of records.

We found that care plans had not always been reviewed on a regular basis to ensure that the information was accurate and up to date. Care plans on Renwick and Edward units had not been reviewed since September 2015. Similarly, records examined on the ground floor contained gaps in the review of care plans and some risk assessments. This meant there was a risk that care and treatment may not meet people's needs. These gaps had not been picked up during routine audits by the manager.

Staff told us that they were unable to bath people as often as they would like to. One said, "We have no time for baths." We checked individual care records and found that there was no record of some people having had a bath or a shower, and for other people very few were recorded. We found that in addition to personal records, baths were recorded in a separate bath book. We were able to find that some people had received more baths than documented in their individual record, but for some people there were few or no records of baths or showers in either record.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Detailed pre admission assessments were carried out before people moved into the service. This meant that staff were aware of the needs and preferences of people immediately.

There was a varied activities programme in place. Some activities were advertised on the notice board, and the newsletter in reception described activities that had taken place, and provided future "dates for your diary" of activities planned. Activities advertised included arts and crafts, tai chi, Just Jhoon, a Bollywood style dance class which people had enjoyed very much, church service, afternoon tea with a school, baking and bingo.

Some visitors came to the service to carry out a Bible stories activity. They said, "It's lovely here, they are very well looked after and the activity coordinator is very good, we come every Thursday."

Visitors and people spoke positively about the activity coordinator. In addition to planned group activities, we saw individual activities such as dominoes, a "pamper" session, and newspapers and resources were available.

A complaints procedure was in place. One complaint had been received by the service but this was responded to outside the timescale described in the policy of the service provider. The manager explained that this was due to a change in senior management, resulting in a delay.

A relatives meeting was held in October 2015 where the main topics were activities. Relatives were invited to share their ideas about future activities. They also discussed the menu which they were happy with.

People living in the service took part in a 'resident's food forum' in October 2015 where they contributed directly to the new winter menu.

Requires improvement

Is the service well-led?

Our findings

We found shortfalls in the maintenance of records relating to people's care and treatment, staff and the management of the service.

There were omissions in the recording and monitoring of fluid intake. Daily fluid targets were not set which meant staff did not always know how much fluid people should be trying to drink on a daily basis. Charts were sometimes incomplete and the total intake was not always added up at the end of the day making evaluation and monitoring difficult.

People's weights were recorded in care plans and also in a separate folder, meaning there were two systems in operation. People's weights were not always recorded in both places, and some weekly and monthly weights were missing entirely. This meant that the nutrition and hydration needs of some people could not be effectively monitored.

We also found inconsistencies with the recording of people's personal hygiene. Care plans were not always reviewed regularly or amended to reflect any changes in people's needs.

We checked staff rotas and noted that it was not always possible to see who covered any shortfalls in staffing since this was not always recorded on the rota. We also found inconsistencies and irregularities with some of the staff supervision records we viewed. We brought some of our findings to the attention of the regional manager for them to investigate further.

The regional manager visited the service a minimum of once per month to carry out audits. They were also available and accessible to staff at any time. They confirmed that they had been in regular contact with staff but none of them had raised any concerns about staffing directly with them. The provider's auditing systems had not identified the above omissions in staff or care records.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014. (Good governance).

We had not been notified of some incidents of abuse between people using the service, for example, as a result of behavioural disturbance or distress. The submission of notifications is required by law and enables us to monitor any trends or concerns and pursue any specific matters of concern with the provider. This is being followed up and we will report on any action once it is complete. The manager told us they were now clear about this requirement.

This was a breach of regulation 18 of the Care Quality Commission (Registration) regulations 2009. Notification of other incidents.

A registered manager was in post. Some staff said they did not feel well led by the manager. Other people and visitors told us the manager was friendly and approachable. One staff member said, "The manager is approachable and listens to us." Visiting professionals said that the manager was accessible and helpful.

The manager had held meetings with people and relatives and staff. The most recent staff meeting minutes was held in September 2015. The focus of this meeting was to discuss activities, to remind staff of certain responsibilities and to praise them for keeping up to date with training. Staff asked whether new staff would be starting but there were no direct complaints or concerns recorded regarding staffing levels.

The manager had carried out surveys relating to the quality of the service and the results of these were displayed. This survey asked whether people were treated with dignity and respect, whether people appeared safe, the general appearance of the home and grounds, cleanliness, and their views on activities and meals. Results were in the main positive. A small number of people were uncertain about the quality of activities and meals, but minutes of future meetings demonstrated that these areas were targeted in focus groups at a later date.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: A system to ensure the proper and safe management of medicines was not fully in place. There was insufficient moving and handling equipment available to meet people's needs and ensure the safety of staff. Regulation 12 (1) (2) (g) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: An effective system to assess, monitor and improve the quality and safety of the service was not fully in place. Records relating to people, staff and the management of the service were not properly maintained to ensure they were accurate and complete. Regulation 17 (2) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	There were not enough staff deployed to meet people's needs. An effective system to ensure staff were supported through supervision was not fully in place. Regulation 18 (1) (2) (a)
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents A system was not in place to ensure CQC were notified of other incidents in line with legal requirements. Regulation 18 (2) (b)