Camellia Care Ltd

Mulgrave House Nursing Home

Inspection report

9-11 Springfield Street
Rothwell
Leeds
West Yorkshire
LS26 0BD

Tel: 0113282193735

Date of inspection visit:
30 October 2018
01 November 2018

Date of publication:
17 December 2018

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

A comprehensive inspection of Mulgrave House Nursing Home, took place on 30 October and 1 November 2018. The inspection was unannounced on day one and announced on day two. At the last inspection in March 2016, the home was rated as 'Good'.

Mulgrave House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mulgrave Nursing Home is a large converted property with a modern extension. The service provides care and support for up to 35 people. The service can support older people, people who are living with dementia and people who have a physical disability. Some people are supported with intermediate care, prior to them returning home or going on to another care service. The service is close to all local amenities.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were not always managed safely. Stocks of medicines did not always balance with records and creams were not always applied as prescribed.

Systems and processes for monitoring the quality of the care provision required strengthening. The registered manager was in the process of introducing a new quality management tool, but it was too soon to be able to assess how effective this would be. Feedback regarding the management team was positive.

People's care plans did not always provide accurate and up to date information about their current needs to provide effective care. Some information in the care plans was contradictory.

There were sufficient numbers of staff deployed in the home and feedback from people and staff confirmed this. Recruitment was safely managed, as relevant checks undertaken ensured staff were suitable for working with vulnerable people. Staff completed induction and there was a training programme in place. Timely staff supervisions and appraisals were carried out; staff said they felt supported by the registered manager.

Some risks to individuals were appropriately assessed, monitored and reviewed. Building maintenance and fire safety was appropriately managed as the necessary checks had been completed. People felt safe and staff knew how to recognise and respond to signs of abuse. The home was clean, tidy and odour free. There were procedures in place to reduce the risk and spread of infection. Communal areas of the home were comfortably furnished and people were familiar with the layout of the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service did support this practice. We found the service was working within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, decision specific mental capacity assessments were not always in place.

People's healthcare needs were met and they were able to access a range of healthcare professionals. People were happy with the food they received. Throughout the day, drinks and snacks were regularly provided. We observed a positive mealtime experience where people were well supported.

Staff were seen to deliver caring, kind and compassionate care. Comments from people and relatives confirmed staff provided good care. The home was warm, with a friendly atmosphere, there were good natured interactions between people and staff. People's privacy and dignity was respected.

People received stimulation through a programme of activities with external entertainers and trips out to local facilities also took place.

The registered manager told us they had a good reputation with supporting people who were approaching the end of their life. We saw care plans mostly contained individual information regarding peoples wishes.

People and relatives knew how to complain. Complaints were appropriately dealt with and responded appropriately by the registered provider. However, not all the documentation was in the complaints file, which made it difficult to establish an evidence trail.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to medicines management and 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.

Medicines were not always managed safely.

There were sufficient numbers of staff deployed in the home. Recruitment of staff was safely managed and relevant checks had been carried out.

People felt safe. Some risks were appropriately assessed, monitored and reviewed. There were effective systems in place to reduce the risk and spread of infection.

Is the service effective?

Good

The service was effective.

Staff received an induction and appropriate training. Timely staff supervision and appraisals were completed.

MCA and DoLS were appropriately managed. Staff knew to offer people choice and what to do in the event they refused care, although some records were not decision specific.

People had access to a range of healthcare professionals and services. People were complimentary about the food and we observed a positive mealtime experience.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about the care they received. Staff were familiar with people's care preferences and care was centred on individual's needs.

Privacy and dignity were respected. People were supported to be independent as much as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Not all care plans contained accurate information and some sections contained conflicting information.

There was a system in place to manage complaints, although not all the documentation was in the complaints file.

Activities were on offer and there were some good links with the local community. The registered manager promoted a person-centred approach to end of life care for people.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Effective quality assurance systems were not robust in assessing and monitoring the service to help drive improvement.

Staff, people and relatives were complimentary about the management team. There was a positive culture amongst the staff team.

Action was taken to seek the views and opinions of people and staff.

Mulgrave House Nursing 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.

A comprehensive inspection took place on 30 October and 1 November 2018 and was unannounced on the first day and announced on the second day. On day one, the inspection team consisted of two adult social care inspectors, a specialist advisor in governance 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. On day two, the inspection team consisted of two adult social care inspectors.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch England, and local authority safeguarding and commissioning teams. Healthwatch England is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

On both days of our inspection, there were 29 people living at Mulgrave House Nursing Home. We spoke with the registered manager, three nursing staff, a team leader, a therapy assistant, a chef, two domestic staff and the activities coordinator. We also spoke with six people who used the service, four relatives and a visiting healthcare professional.

We spent time observing care in the lounge area and used the Short Observational Framework for

Inspections (SOFI). This is a way of observing care to help us understand the experience of people who used the service who could not express their views to us. We looked at three people's care plans in detail and a further three care plans for specific information. We inspected staff recruitment records, supervision, appraisal and training documents. We also sampled seven people's medication administration records. We reviewed documents and records that related to the management of the service, which included audits.

Requires Improvement

Is the service safe?

Our findings

Some areas of medication management were not safe. We checked a random selection of medicines to see if the stock tallied with the number of recorded administrations, but we were not able to reconcile all the medicines we checked. We noted two people had not received their medicines as prescribed. For example, on two separate occasions, one person had been administered more than was prescribed of a specific medicine. We saw a medicine was entered twice on their medication administration record (MAR), once by the pharmacist and once handwritten by staff.

A second person should have been administered 14 tablets in a set period but we saw they had only received 13 of them. The nursing staff we spoke with were unable to explain why or how this had happened. This meant we could not be sure people were receiving their medicines as prescribed. We brought this to the attention of the registered manager and by the second day of our inspection, they had taken action to address the concerns found with the administration of medicines.

We looked at how staff administered prescription creams. These were applied by care staff and a topical medication administration recorded (TMAR) was completed. Nursing staff signed the MAR with a 'Z' which meant care staff had applied the cream, although, the TMAR and MAR did not always match. Nursing staff did not check with staff or records to see if creams had been applied, and whether this was the correct frequency. This meant we could not be sure people's creams were applied as prescribed. On day two of our inspection, a new process for the administration of creams had been introduced.

The providers medication policy dated August 2017 stated, 'On administering 'as required' (PRN) medication, the nurse must also note on the reverse of the MAR and the care plan with the time of the dose, the reason for the dose, its effectiveness and the reason why the dose was chosen if a variable dose is prescribed'. We found PRN medicines were not recorded on the reverse of the MAR.

One person's medicines, which should have been administered routinely, was treated as PRN medicine. For example, one person had been prescribed a pain relief medicine to be taken 'four times a day'. The letter 'N' had been recorded on the MAR, which meant 'not needed'. This meant people may not have received the correct dosage of prescribed medicine as it was not being administered in line with prescribing instructions. Following our inspection, the provider told us that there was an agreement in place with the person's GP that this medicine should be taken on an 'as required' basis.

Care and treatment was not provided in a safe way for people who used the service because the management of medicines was not fully safe. This is a breach of Regulation 12(2)(g); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 'Safe care and treatment'.

People told us they received their medication when they should. One person said, "I get my medication on time." We observed staff administering medication, which was done in a kind and patient way with staff explaining what the medicine was for.

Relevant staff had completed medicines training and competency checks had been carried out for staff who administered medicines.

The room in which medicines were stored was small but organised and tidy. Room and fridge temperatures were recorded daily. Controlled drugs were stored and administered appropriately.

People and relatives told us they or their family member felt safe living at the home. One person said, "I feel safe, I'm happy here." A relative told us, "I'm very happy [name of person] is here; I'd give it 10 out of 10."

Staff had received safeguarding training, which was kept up to date. Safeguarding policies and procedures were in place. Staff were clear about how to recognise and identify types of abuse and knew what to do if they witnessed any incidents. The registered manager had reported any incidents to the Care Quality Commission as required. This demonstrated the manager and staff were aware of their responsibilities in keeping people safe.

Each of the care plans we looked at contained a variety of risk assessments. There was guidance about what action staff needed to take to reduce or eliminate the risk of harm. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum necessary restrictions. We observed one person being assisted with a hoist. This was done safely and staff explained what they were doing as they were assisting the person.

We saw people had personal emergency evacuation plans, which identified individual moving and handling needs should the home need to be evacuated in an emergency. However, these, at times, were difficult to read.

Fire safety was satisfactorily managed. The home's records showed fire safety equipment was tested and fire evacuation procedures were practiced. Fire extinguishers were present and in date. Staff had received fire safety training. Annual inspections were carried out regarding emergency lighting, the fire alarm and the sprinkler system. We saw several health and safety checks had been carried out, which included equipment used in the home and water testing. Gas and electrical safety certificates for the home were in date.

People and their relatives told us there were enough staff to meet their needs. On person said, "There are plenty of staff." A relative told us, "There are plenty of staff about."

There were sufficient numbers of suitably deployed staff to meet people's needs on both days of our inspection. One staff member told us, "There is always plenty of staff. The staffing levels are good."

We looked at the recruitment records for two members of staff. The records showed safe recruitment practices were followed. Appropriate checks were undertaken before staff began work. This included a Disclosure and Barring Service (DBS) check and references were obtained. The DBS checks assist employers in making safer recruitment decisions by checking prospective care workers are not barred from working with vulnerable people. This meant the home had taken steps to reduce the risk of employing unsuitable staff.

People and their relatives told us the home was clean. One person said, "The home is very clean." A relative told us, "It's very clean. You always see the cleaners." A second relative told us, "I can't believe how clean it is. They change the bed every day."

We looked around the home and found the premises were clean, tidy and odour free. Communal bathrooms

were clean and well-maintained with soap dispensers, liquid soap, paper hand towels and plastic bins for used towels. Staff had access to personal protective equipment, such as gloves and aprons and alcohol hand rub was available on the corridors. We saw an infection control audit was carried out in February 2018, actions were taken if issues were identified. A staff member told us precautions were taken, where needed, and cleaning protocols were followed.

Lessons were learnt and improvements made when things went wrong. The registered manager told us they had learnt lessons from information sharing at meetings with other managers. For example, falls analysis did not previously record contributory factors, but was now included. They also told us the introduction of the intermediate care service had been a 'year-long learning curve'. We noted the recording of evidence for lesson learnt needed to be clearer.

Good

Is the service effective?

Our findings

People and relatives told us staff knew how to look after them or their family member. One person said, "Staff know what they are doing." A relative said, "The staff have done a lot for [name of person]. He looks a lot better than when he came in."

The registered manager told us staff received an induction when they commenced employment. This included completing relevant training, working with more experienced staff and guidance on care and support should be provided. A staff member told us, "There is induction paperwork, which tells staff about things such as bathing and support with meals. I would go through this with new staff."

Training records we looked at showed staff were up-to-date with their training requirements. The registered manager told us there was a system in place to monitor all staff training and to make sure refresher training was completed. All staff had completed or was in the process of completing the Care Certificate. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours. This ensured people continued to be cared for by staff who had maintained their skills.

Staff confirmed they received supervision where they could discuss any issues on a one to one basis. Staff files confirmed supervision meetings had taken place. Annual appraisals had been completed in 2018.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

People we spoke with told us they were offered choice and asked for their consent prior to staff carrying out care and support. One person said, "I get to make choices about what I do such as activities and when I get up. They ask consent and tell me what they are doing." We observed staff supported people to make choices throughout the day.

The registered manager and staff had a good understanding of the MCA and the DoLS. Staff were able to give examples, of when and why a DoLS would be applied for. The registered manager told us five applications for DoLS had been completed following a mental capacity assessment and had been submitted to the local authority. They said they were waiting to find out if these had been authorised.

The care plans contained some decision-specific mental capacity assessments. One person's decisions had been recorded in line with best practice; recording them would show relevant people had been included in the decision-making and ensure the rights of people were respected. The registered manager told us they would review people's mental capacity assessments. We have referred to some of the issues identified, under the well-led section of this report.

We saw examples where people's care and support was delivered in line with legislation and evidence based guidance. For example, the registered manager told us they were guided by the National Institute for Health and Care Excellence for the management of medicines. They also used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards when providing personal care. They said they had worked with a local university to carry out research into 'dementia care mapping'.

People told us they liked the meals and were given choice. One person said, "The food is good; you get a choice. They will make you something different if you don't want what is on the menu."

On day one of our inspection, we observed both the breakfast and lunchtime meals in the dining room. People were asked what they wanted and there was flexibility if they wanted something different to the menu. We saw where people who required some support with their meal, staff sat and chatted with them as they ate their food.

The chef told us a four-weekly menu was in place. They said there were no issues with the quality of the food and the food suppliers were all local; fresh fruit and vegetables were delivered twice weekly. They said they were aware of people's dietary requirement. The chef told us there were always biscuits and sandwiches left in the fridge overnight for people. Care staff could also prepare toast and sandwiches, if needed. We saw throughout the day drinks and snacks were offered to people.

Staff attended handover meetings at the start of each shift where they were updated on people's care and support needs. We saw staff worked well as a team, communication between the nursing and care staff could be more effective. Before the inspection, we requested feedback from the local clinical commissioning group, who identified some minor recommendations in July 2018.

People told us, if needed, a GP or other healthcare professional would be contacted. One person said, "The staff get the doctor if I need to see them." A relative told us, "The staff have made a referral to the physiotherapist." We saw evidence in the care plans people received support and services from a range of external healthcare professionals.

Some people were seen by therapists on a regular basis as part of the intermediate care service provided in the home. The registered manager told us a weekly meeting was held, with a consultant, advance nurse practitioner from a local GP's surgery and on-site staff to discuss people's healthcare needs.

People who lived at the home on a permanent basis, had bedrooms that were personalised with pictures, photographs and personal mementoes. People who were at the home for a short period of time had brought some pictures and personal belongings with them. Communal areas were decorated in a homely style, which created a relaxed and informal atmosphere. Each day, part of the dining room was turned into 'café' style; people could visit and order drinks and snacks. People had access to the garden, which had seating areas.

There was some signage around the home allowing people to distinguish the different areas. However, areas were not decorated in contrasting colours, which could help people who had a cognitive impairment

to orientate themselves in the home.

Good

Is the service caring?

Our findings

People and relatives told us the home was very nice and they received the care and support they needed. One person said, "Everybody is lovely." Another person said, "I'm well treated by the staff." A relative told us, "The standard of care is exceptional. It's an example to other care homes. My mum has particular needs that they meet." A staff member said, "When I come to work, I treat them [people] how I would like my family members to be treated."

People were very comfortable in their home and decided themselves where to spend their time. The premises were spacious and allowed people to spend time on their own if they wished. We saw some people sitting in one lounge area listening to music whilst other people sat in another lounge watching television. Some people were spending time in their bedroom.

On one of the doors in the home, we saw a sign that stated, 'We care for our residents as we would care for our own loved ones'. Throughout our two-day inspection of the home, the atmosphere was relaxed, warm and friendly. We saw numerous examples of light-hearted banter between people, relatives and staff. It was clear staff and the registered manager knew people very well and people were relaxed and comfortable in the presence of staff. Staff spoke clearly when communicating with people and care was taken not to overload the person with too much information. Staff we spoke with were able to tell us about people's individual needs, likes and dislikes.

Every person was greeted by name and staff spoke with people when passing and often stopped for a chat. All staff were attentive and kind during their interactions with people. For example, we heard a staff member ask one person if they had enjoyed their breakfast, if they wanted anything more to eat, was there anything else they wanted and if they were warm enough.

People looked well cared for. People were tidy, well dressed and clean in their appearance which was achieved through good standards of care and support.

People we spoke with were not sure if they had seen their care plan. From the care plans we looked at, we did see some involvement from the person and/or their relative., A staff member told us they would ask the person about their preferences and how they wished to be cared for.

Information about advocacy services was available to people, however, none of the people who used the service had needed to use an advocate recently.

People told us their privacy and dignity were respected. One person said, "The staff treat me with respect. They ask me what I want, such as I like my door left open." A relative told us, "The staff asked my wife if she was happy to have a male carer."

Staff were able to give examples of how they maintained people's privacy and dignity. For example, by closing doors and curtains when providing personal care. One staff member said, "When the doctor is

coming for an examination, we take the person to their room for their own privacy. It is not right to speak to the doctor about somebody when everybody is sitting around and can hear about it." Another staff member told us, "When in the bathroom, I put a sign on the door to make sure people don't enter. You don't want people coming in and out, especially when people have been used to living at home by themselves." We saw staff knocked on people's bedroom doors and privacy was maintained during moving and handling tasks.

People said staff encouraged them to retain their independence. One person said, "They help me to be independent. They support me in dressing myself." A relative said, "When my mum first arrived, they would feed her. I explained she could feed herself and they now support her in doing this independently."

We saw there were good links with the local church, ensuring people could attend a variety of events as and when they chose. Church services were displayed in the home. Staff supported people with whatever spirituality meant to them as an individual. We saw recorded in one person's care plan they wished to follow a specific faith. This helped to support people's spiritual, religious and cultural needs.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before moving into the home. This helped to ensure people's needs could be met. We looked at three people's care plans in detail and three other care plans for specific information.

The care plans contained lots of information, which included people's likes, dislikes, hobbies, interests and how people should be supported. However, some sections of the care plans were handwritten, which made them very difficult to read.

Some areas of the care plans provided inaccurate and conflicting information. For example, two people's nutritional needs were not consistently recorded across all the documents in the care plan, which meant there was a risk their nutritional care may not be delivered in line with the most up to date instructions, and this may have had a negative effect on their health and wellbeing as a result. Another example was one person's night care plan, which stated that a special mattress was required; when we checked, the person was on a normal mattress and the registered manager told us they did not require a special mattress.

Some sections of the care plans had no record of a review for some time. For example, one person's risk assessment for attendance at medical appointments was dated January 2017. The registered manager said this had not been updated as nothing had changed but agreed this needed to be recorded.

We noted one person used a profile bed with an air mattress, but there was no information recorded to inform staff which setting the mattress should be set to. It is important these mattresses are set correctly to ensure they provide effective pressure relief to people who may be at risk of developing pressure ulcers. A staff member told us the mattress was set according to the person's weight. Following our inspection, the provider told us information about the settings that air mattresses should be set to were stored in people's bedrooms and in the nurse's station.

A staff member told us one person may hide medication. However, they said this was not written in their care plan. It was important all staff had this information to refer to.

Not having accurate and up to date records about people was a breach of Regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 'Good governance'.

People told us they were supported to keep links with family and friends. One person said, "My son comes most days. He feels very welcome and is able to come whenever he wants." A relative told us, "I visit when I want. I know the staff well; they always talk to me."

People said they were told about the activities and could take part if they wished. One person said, "I don't do many activities but they always let me know what is happening so I can choose." A relative said, "She does the singalong and is getting more involved."

The activities coordinator organised a variety of activities, which were published on posters around the

home; a newsletter was available to people and visitors. The activities included singalongs, exercises and outings. In addition, there was a quarterly visit from a local donkey sanctuary.

People told us they would know how to make a complaint if they needed to. One person said, "I've never made a complaint but I would have no worries about approaching the staff." Another person said, "I know who to complain to if I need to." A relative said, "We made a complaint shortly after [name of person] arrived as they weren't dealing with one of their medical conditions properly. They [registered manager] contacted a local specialist and made sure all the staff were trained."

We looked at the way complaints were handled and noted these were investigated and addressed by the registered manager, although not all the documentation was in one file, making it difficult to establish an evidence trail. We saw the complaints procedure was displayed in the entrance area to the home.

The registered manager told us the home had a good reputation for providing end of life care to people. The wishes of people who were approaching the end of their life had been recorded in care plans. However, we noted one person's advanced care plan had not been reviewed since April 2017. The registered manager told us they would have expected this to have been reviewed and updated, if needed.

As people entered the final stages of their lives, the home was supported by the local hospice and relevant healthcare professionals. A staff member told us the provider and registered manager supported staff by arranging training in end of life care. This ensured staff felt confident in meeting the needs of people and their relatives at this important time.

The Accessible Information Standard requires the provider to ask, record, flag and share information about people's communication needs and take steps to ensure people receive information which they can access and understand, and receive communication support if needed.

The registered manager was aware of the Accessible Information Standard. We found information regarding people's communication needs was recorded their in care plans.

The manager told us documents could be produced in any format or language that was required.

Requires Improvement

Is the service well-led?

Our findings

Systems were in place to monitor the quality and safety of the service. We saw health and safety checks and infection control audits were effective in maintaining the safety and cleanliness of the home. However, not all audits were effective. The registered manager completed a medication audit in October 2018, where the only action was that people's allergy status needed to be added to medication administration records. This meant the audit failed to highlight the issues found during this inspection, which could lead to people's medicines not been managed in a safe way. Audit processes needed enhancement to make sure these were effective and demonstrated changes had been embedded in practice.

The registered manager told us they completed a monthly care plan audit. But we found the care plans we saw required some updating. This meant the registered manager had failed to highlight the issues found during this inspection, which could lead to people not receiving the correct care and support to meet their needs. Following our inspection, the provider submitted 13 care plan audits form October 2018, along with an action plan for each one. The provider stated, 'The quality assurance procedure requires a check on 10% of care plans', although, we were not able to establish if any of the care plan audits were for the care plans we reviewed at the time of our inspection. We did identify some areas of the care plans audited required updating. For example, one person's action plan stated, 'care summary, need to rewrite with new advice from SALT.

During our inspection, we noted other concerns with the completion of documentation which had not been identified by the management team. For example, people's care plans were not easy to read and contained inaccuracies. Personal emergency evacuation plans (PEEPs) were also difficult to read and the PEEPs 'grab' sheets required further detail adding regarding people's requirements. Clearer recording was required for the decisions people could make and how lessons were learnt to drive improvement.

Management oversight of the service required strengthening. We noted a nurse's registration with the Nursing and Midwifery Council (NMC) was due to expire but the registered manager did not have a system in place to make sure they had an awareness of these renewal dates. If people want to work as a nurse or a midwife in the UK, they must register with the NMC. The medication policy contained out of date information and would benefit from being reviewed.

The registered manager was in the process of introducing a new quality management tool, which showed a range of audits and the frequency these were going to completed. However, this had not been implemented at the time of our inspection.

The registered provider did not have effective systems in place to assess, monitor and improve the quality of service provided. This is a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 'Good governance'.

People and their relatives were complimentary about the management team. A relative told us, "I've met the manager, she was very helpful." People told us staff were approachable and there was always someone to

talk with, but not every knew who the registered manager was. One person said, "Everybody is lovely" and another person said, "It's absolutely gold here."

We saw staff had a relaxed and friendly relationship with management. Staff spoke positively about the management team. One staff member said, "I love working here." Another staff member said, "It is like a family. Everybody is approachable. I know that I can come to work and if I am worried or need to know anything I can approach [name of registered manager]. I can also approach [name of deputy manager]; I can approach anybody and they will sit and talk to you."

Twice yearly resident meetings were held and a resident satisfaction survey was completed in 2018. We saw responses to the satisfaction survey were very positive.

A staff satisfaction survey was completed in Spring 2018. A low response rate was noted, but there we no major areas of concern and an action plan had been put in place. Staff meetings took place between the management team and the wider staff team. The last team leaders meeting was March 2018 and the last nurse's meeting and the one for general staff was April 2018.

The registered manager said they worked in partnership with other organisations to provide effective outcomes for people they supported. These included shared learning between the provider's other homes. They said they worked with healthcare professionals, when needed, to support people's health needs. The registered manager said they had been part of a research project with a local university, which had looked at 'Dementia Mapping' within the service. The results were limited but the registered manager said they had implemented some learning from this. For example, the staff approach to people was now calmer and quieter.

Notifications had been sent to the Care Quality Commission (CQC) by the home as required by legislation.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people who used the service because the management of medicines was not fully safe.

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 Even though the registered manager and staff knew people well, care plans did not reflect people's current or accurate needs. This meant people were at risk of not receiving the appropriate care and support they required. The registered provider did not have effective systems in place to assess, monitor and improve the quality of service provided.