Norens Limited

Homecrest Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Homecrest Residential Home provides personal care and accommodation for up to 29 people. The home is in Wallasey, Wirral. The property is a three storey building with a small car park available at the front. Bedrooms are single occupancy with ensuite toilet facilities. A passenger lift enables access to bedrooms located on upper floors for people with mobility issues. On the ground floor, there is a communal lounge, dining room and conservatory for people who live at the home to use.

The home has a registered manager. 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.'

During our visit, we found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014. These breaches related to the provision of safe and appropriate care, medication management, complaints and the management of the home You can see what action we told the provider to take at the back of the full version of the report.

We reviewed three care records. We saw that care plans contained person centred information about the person and their life prior to coming to the home. Each care plan was holistic and reflected people's needs and care. Risks associated with people's care were assessed and staff had guidance on how to manage these conditions to prevent further decline. We found however that professional advice in relation to one person's nutritional risks had not been appropriately followed up. This meant that staff could not be sure that the support provided was the safest way to manage the person's nutritional risks. This placed the person at potential risk of harm.

Some of the moving and handling techniques used by staff in support of people's mobility needs were inappropriate and placed people and staff at risk of accident and/or injury. We asked the manager to address this immediately.

The premises and equipment at the home had been regularly checked and inspected. Records showed persistent faults with the passenger lift and we saw that this had impacted on at least one occasion on the delivery of care. We spoke to the provider about this. They assured us that work was due to take place to resolve this. We found that some of areas of the home were unbearably hot. Elderly people are at increased risk of infection and dehydration in high temperatures. No appropriate action had been taken to ensure that temperatures were monitored and adjusted so that people were protected from any potential health risks arising from unsafe room temperatures.

Medication was given to people in an appropriate and pleasant way but the way in which medication was accounted for at the home was not satisfactory. This meant discrepancies in stock levels and administration errors were not always picked up.

People's nutritional needs and risks were assessed and planned for. People were given a choice of suitably nutritious meals of sufficient quantity. People told us the food was satisfactory but that a bedtime drink was no longer routinely provided which meant that sometimes the last drink they received was at teatime. This meant there was a risk that some people would go long periods without a drink. We saw that one person required a pureed diet. The way in which this diet was prepared required improvement to ensure their dietary intake was supported in the best way possible. People who required assistance to eat at mealtimes where supported in a patient, sensitive manner by staff.

Where people had mental health issues, care plans contained person centred information to enable staff to understand the person and the impact these mental health issues had on their day to day life. We saw that there were the beginnings of good practice in relation to the implementation of the Mental Capacity Act. We saw that where people were deprived of their liberty, people's capacity to keep themselves safe outside of the home was assessed prior to this decision being made. This was in accordance with legislation designed to protect people's legal right to consent. We found however that capacity assessments lacked evidence of the person's involvement in their own assessment and the decision making process. The implementation of the mental capacity act required further development in this area.

We noted some elements of good leadership in the service. People told us they were happy with the care they received and said they were well looked after. We saw that people had prompt access to any medical or other health related support as and when required and that their care was delivered in accordance with their care plan. People looked well dressed and content. Staff supported people in a patient, unhurried manner and people looked relaxed and comfortable in the company of staff. Staff we spoke with had an understanding of people's needs, preferences and life prior to coming into the home.

Staff were recruited safely and the number of staff on duty was sufficient on the days we visited. Staff were seen to be confident in their job role, work well together as a team and told us they felt supported by the manager. Records showed that staff had received the training they needed to meet people's needs.

People said they felt safe at the home and had no worries or concerns. Staff had received safeguarding training and demonstrated an understanding of safeguarding when asked. We saw that safeguarding incidents were reported to and investigated by the Local Authority to protect people from risk. Some of these incidents had not been reported to The Care Quality Commission.

Accident and incidents were appropriately monitored and referrals made to the falls prevention team when necessary. There were systems in place to ensure that the risk of Legionella in the home's water system was managed and there were a range of health and safety checks in place that ensured the home's equipment and environment was safe. Other aspects of service management required improvement.

For example, the use of poor moving and handling techniques had not been picked up and addressed by the manager or provider. There were no management systems in place to monitor staff supervision and appraisal and the way in which this support was provided did not comply with the provider's policy.

The provider's medication policy was not consistently followed and medication audits were meaningless and ineffective in picking up stock discrepancies, administration errors and the disorganised way in which medication was accounted for.

The provider's complaints policy did not give people clear information on how to make a complaint or who people should complain to. The manager told us no formal complaints had been received since our last inspection in 2013 but shortly after our visit however we received a complaint about the provider. We

reviewed the provider's response to this complaint and found that the wording of the provider's response was not appropriate.

People's views on the quality of the service had been sought with positive results.

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 told us they felt safe living at the home. Staff were knowledgeable about types of abuse and who to report concerns to.

Risks in the delivery of care had been assessed but professional advice was not always consistently followed up.

Staff were recruited safely and the number of staff on duty was sufficient.

Improvements in the way medicines were accounted for was required.

The premises were satisfactorily maintained but room temperatures were uncomfortable in parts of the home and work on the passenger lift was required.

Is the service effective?

Requires Improvement

The service was generally effective but improvements were required in some areas.

People nutritional needs were properly assessed and people were given suitable meals. Access to suppertime drinks and the preparation of pureed diets required review.

People's ability to make decisions was in line with the Mental Capacity Act but lacked sufficient evidence of people's involvement in the assessment process.

People had prompt access to their GPs and access to other healthcare professionals as and when required.

The staff files we looked at showed evidence that staff had appropriate training and support to do their job.

Is the service caring?

Good

The service was caring.

People we spoke with said staff treated them well. Staff were observed to be kind when people required support.

The atmosphere at the home was warm and homely and visitors received a warm welcome

Staff had an understanding of 'the person' they cared for and we observed that the care provided was person centred.

People independence was promoted by staff and care plans gave guidance on what people could do independently and what they needed help with.

Is the service responsive?

Requires Improvement

The service was responsive.

People's care plans contained person centred information to ensure people's care met their needs and wishes.

Interactions between staff and people who lived at the home were warm and person centred. It was obvious staff knew people well.

A range of social activities was provided which promoted people's social well-being.

Complaints information was available but unclear and we found that complaints were not always responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

Some quality assurance systems were in place to monitor the quality of the service but they did not effectively ensure that risks to people's health, safety and welfare were picked up and addressed.

People's opinions of the quality of the service had been sought. The feedback gained was positive.

Homecrest Residential 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 19 and 22 August 2016. The first day of the inspection was unannounced. The inspection was carried out by an adult social care (ASC) Inspector. Prior to our visit we looked at any information we had received about the home.

During the inspection we spoke with three people who lived at the home, a relative, two care staff, the registered manager, the deputy manager, the maintenance officer, the provider and a visiting healthcare professional.

We looked at the communal areas that people shared in the home and some of their bedrooms. We reviewed a range of documentation including three care records, medication records, three staff files, policies and procedures, health and safety audits and records relating to the quality checks undertaken by the registered manager.

Requires Improvement

Is the service safe?

Our findings

During our visit, we looked at the care plans belonging to three people who lived at the home. We saw that people's risks in relation to malnutrition, falls, moving and handling, level of dependency, pressure sores and people's emotional well-being were all assessed. There were management plans in place to reduce any potential risks and there was evidence that these management plans were followed by staff.

We found the care plan and risk management plan relating one person's care had not been consistently updated with some of the professional advice given or followed-up with the person's GP as advised by the professional involved in their care. We asked the manager about this. They acknowledged that they were unaware of the advice and as a result had not followed this up with the person's GP. This placed the person at risk of potential harm.

We saw that appropriate action was taken to access suitable support for people who were injured as a result of an accident or incident. Information we reviewed prior to our visit showed that the Local Authority had visited the home in January 2016 and raised concerns with the manager about the moving and handling techniques used by staff. A healthcare professional had also raised safeguarding concerns about the techniques observed at the home in June 2016 which had resulted in injury to one person. Despite this, we found no effective action had been taken to address the moving and handling techniques in use. We observed four incidences during our visit where inappropriate moving and handling techniques were used to support people with mobility issues. These techniques placed people at significant risk of an accident or injury. We spoke to the manager about this. They acknowledged that the techniques we observed were inappropriate. We asked the manager to address this immediately.

During our visit, we found that some of the communal areas such as the dining room, conservatory and lounge were unbearably hot. Staff we spoke with told us that these areas were always hot. One person's relative arrived after lunch and removed them immediately from the conservatory where they were sitting. We overheard them remark to the person that the conservatory was 'too hot' for them to be sitting in. During the afternoon, two members of staff had sweat visible on their faces.

We used a thermometer to take the temperature of the dining room and conservatory and saw that the temperature gauge hit the 80 degrees centigrade mark. Vulnerable elderly people are at risk of contracting an infection or dehydration in high temperatures. People who live with chronic illness such as Parkinson's disease and diabetes, and those people with mental health conditions that mean they may not recognise the need to adapt their behaviour to keep cool, were at increased risk. We asked the provider to open some of the windows and to take further longer term action to address the unsafe temperature in the home.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately addressed.

We checked the arrangements for the management of medication. We saw the majority of people's

medication was stored safely in a locked medication room but we found some people's prescribed creams were stored un-securely in their bedrooms. This meant it was accessible to other people who lived at the home and their visitors which placed it at risk of unauthorised use or removal. We spoke to the manager about this.

On checking a sample of three people's medication administration charts with the deputy manager, we found that the balance of medication in stock for two people did not match what had been administered. We asked the deputy manager about this. They were unable to explain the discrepancy.

We saw that way in which medication was booked into the home was chaotic. The medication room was disorganised with medications due to be booked in. There were sheets of paper with hand written, back tracked calculations relating to the medication administered in the previous month. This made it difficult for staff to tell if the amount of medication in stock at the home was correct at the time any new medication was received. It was also not possible to properly account for the administration of boxed medications such as painkillers and medicines to be given 'as required' as staff had not recorded the quantity of medicines brought forward from the previous month at the start of the new medication cycle.

We looked at one person's medication administration record and saw that on two occasions the manager had administered double the dose of medication than any other staff member. We checked the administration instructions on the person's medication box and saw that it instructed staff to give the person two tablets daily. The majority of staff had given the person one tablet in the morning and one in the evening. The manager however had administered two tablets in the morning and two in the evening. This meant there was a risk the person had been given double the dose of prescribed medication. We asked both the deputy manager and manager about this. Both were unaware of what the actual correct dose of medication was and neither had picked up that a change in the amount of medication given, had occurred on two separate occasions. We asked the manager to clarify the administration instructions with the person's GP without delay.

These incidences were a breach of Regulation 12 as the provider did not have suitable systems in place to ensure the proper and safe management of all medicines in the home.

Records showed that senior staff were trained to administer medication. We observed a medication round and saw that medication was given in an appropriate and pleasant way.

Regular environmental safety checks were carried out on the premises and the equipment in use at the home. The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected by external contractors who were competent to do so. The kitchen was awarded a five star food hygiene rating from Environmental Health in February 2016. This meant food hygiene standards were rated as "very good".

From the provider's records we saw that the home's passenger lift had experienced intermittent faults over a period of eight months which meant at times it was out order. We saw that this had impacted directly on one person's care. We could see that repair work had been carried out on the lift but that the faults persisted. We spoke with the provider about this, who gave us firm assurances that work to finally resolve these issues had been organised with a competent engineer.

The home was clean and there was sufficient protective personal equipment for staff to use in the delivery of personal care. There were systems in place to assess and mitigate the risk of Legionella infection in the home's water supply and we saw that action was in progress to address any issues with water temperatures.

We looked at three staff files. All the files we looked at showed that the necessary checks to ensure that staff employed were of good character and suitable to work with vulnerable adults had been undertaken. Staffing levels during our visit were observed to be sufficient. The provider had a system in place to assess and monitor staffing levels based on the number of people who lived at the home. This system could have been further improved by including people's dependency information so that the provider could be assured that the number of staff on duty matched people's level of need.

At the time of our visit twenty seven people lived at the home. Some people had communication difficulties due to declining mental health. This meant they were unable to talk to us. During our visit, we spoke with two people who lived at the home and a relative. We also spoke with a visiting health care professional. The people we spoke told with said they felt safe and well looked after. The relative we spoke with confirmed this.

We saw that the provider had a policy and procedure in place for identifying and reporting potential safeguarding incidents. This policy failed to provide contact details for the local authority safeguarding team and the Care Quality Commission to whom allegations of abuse should be reported. We spoke to the manager and about provider about this. We spoke with one staff member about safeguarding and found that the staff member knew how to spot potential signs of abuse and who to report safeguarding concerns to. We saw that staff had received training in the safeguarding of vulnerable adults.

We reviewed a sample of safeguarding incident records. We found that safeguarding concerns were appropriately reported to the Local Authority and investigated in accordance with local safeguarding procedures. Some of safeguarding incidents had not been reported to the Care Quality Commission. We spoke to the manager about this.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us the care was good and that staff looked after them well. One person told us "Staff are very good" and the relative we spoke with said the staff were "Excellent" and that they were really happy with the care the person received. Staff we spoke with had an understanding of people's needs and spoke warmly about the people they cared for.

We looked at the care files belonging to three people who lived at the home. The care files we looked at indicated that people lived with varying degrees of memory loss and confusion. Some people lived with dementia. Where people lived with dementia or short term memory loss, their care plans contained adequate information about how these conditions impacted on their day to day life and their ability to consent to any care decisions made. People's care plans also provided information on people's wishes in relation to their care.

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 so that they can 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. We found the beginnings of good practice in relation to the implementation of Mental Capacity Act legislation.

We saw that Deprivation of Liberty Safeguard applications had been made to, and been approved by, the Local Authority in relation to the care of some of the people who lived at the home. The deprivation of liberty safeguards put into place prevented people from leaving the home of their own accord. We saw that a capacity assessment in relation to each person's capacity to keep themselves safe outside of the home was completed prior to an application to deprive them of their liberty being made. This was in accordance with the Mental Capacity Act 2005. There was limited information in people's capacity assessments however to show how the conclusion that the person's capacity was impaired had been arrived at.

For example, one person's mental capacity information and DoLS application stated that the person's health and safety would be compromised if they were allowed to leave the home of their own accord but offered no explanation as to why or what alternative least restrictive options had been explored before a decision to deprive them of their liberty had been made. There was also no evidence that the person had been involved in their own capacity assessment.

Consent forms for the sharing of information and taking of photos for example, were in place in all three care files we looked at. For some of the people, these consent forms had been signed by a relative. The Mental Capacity Act 2005 (MCA) states relatives cannot be asked to sign consent forms when a person lacks

capacity unless they have authority to make health and welfare decisions for the person under a Lasting Power of Attorney or a Court Appointed Deputy.

We observed lunch. We saw that people had the choice of eating their meal in the dining room, the lounge or their own bedroom. People had two choices for lunch and tea and we saw that the food provided was of sufficient quantity. Food was served pleasantly and staff were overheard offering people alternatives if they did not like what was on offer.

We found that the dining room and conservatory where some people ate their meals was uncomfortably hot and at times chaotic. This did not promote a pleasant dining experience. We also found that the period between lunch finishing and tea time beginning was short. For instance on both days of inspection, the lunch period finished around half 1 with tea being served at 4pm.

People we spoke with also told us that the last drink they got was at around tea time and no suppertime drink was provided. One person said the staff came around with the drinks trolley for the last time around 6.30p.m. They did say however they could ask night staff for a drink if they needed one later on in the evening. There was a risk however that those people who lived with dementia type conditions, or those people who were unwell, would forget to ask for a drink when one was needed. Nutritional guidance states that the interval between the evening snack and breakfast the following day should be no longer than 12 hours with a milky bedtime drink offered.

People's care files contained information on their individual nutritional needs and care. Where people had special dietary requirements or where at risk of malnutrition, care plans gave clear guidance on how staff should monitor and manage people's special dietary needs. Information was displayed in the kitchen which identified those people with food allergies or special dietary requirements. People at risk of malnutrition had their dietary intake monitored and received a fortified diet with dietary supplements to promote or maintain a healthy weight.

People were weighed and had their nutritional risks reviewed monthly. People who lived with diabetes had clear diabetic care plans in place and we saw in one person's file that the home had been praised by the community dietitian for the way in which it had helped the person to control their diabetic condition.

We observed one person being assisted to eat in a patient and sensitive manner by a staff member. We saw that due to issues with the person's physical health, the person's meal had been fully pureed together. The meal did not look very appetising. For people who live with dementia, it is important that puréed food is given and presented on the person's plate in their separate food groups as they may be confused by mixed up foods and be unwilling to eat them. This aspect of the person's meal preparation required improvement to ensure the person's dietary intake was promoted in the best way possible.

Records showed referrals to dietary services, occupational health, mental health, falls prevention team, tissue viability services and district nurses had been made as and when required in respect of people's care. Care plans contained information on people's health and medical conditions and gave staff information on the signs and symptoms to spot in the event of ill health.

We spoke with a visiting healthcare professional who told us that staff at the home "Ring us if we are needed before our next visit" and that they acted upon the advice given. The relative we spoke with confirmed this. They told us that staff at the home are "On the phone straightway to the district nurse and/or the person's GP" if the person become unwell or their health needs change. A person we spoke with also said "They get the doctor straightaway, which makes a great deal of difference".

Staff told us they felt supported in their job role and received regular supervision and appraisal. We looked at three staff files and found evidence to confirm this. One staff member told us "This place is fantastic, not just saying that because I work here". Another told us they had "Not had a problem" with regards to support and said they felt fully supported in their job role.

Staff training records showed that staff had access to on-going training opportunities. The staff members we spoke with confirmed this. Staff had received training in health and safety, first aid, moving and handling, dementia, safeguarding, food hygiene, the administration of medication, challenging behaviour and infection control. During our visit inappropriate moving and handling techniques we observed which indicated that staff training and supervision in this area required immediate improvement.

Good

Is the service caring?

Our findings

Staff we spoke with were knowledgeable about people's preferences in the delivery of care and had an understanding of the person they cared for. People told us staff treated them well and a relative we spoke with said "Some of them are angels" when we asked about the staff.

All the care files we looked at showed evidence that people and/ or their families had been involved in planning their care. Care plans outlined the tasks people could do independently and what they required help with. This promoted people's independence.

We observed staff throughout the day supporting people who lived at the home. The atmosphere was warm and welcoming and the interactions between staff and the people they cared for were positive. Staff interacted with people in a warm, kindly manner. They were respectful of people's needs and wishes at all times and supported them at their own pace. From our observations it was clear that staff genuinely cared for the people they looked after and it was obvious that people felt comfortable in the company of staff.

We saw that relatives were made welcome at all times of the day and visited without any restrictions. Interactions with staff were pleasant and visitors were offered a drink during their stay. A relative we spoke with told us that staff at the home had made the person feel very welcome when they first came to live at the home and made their admission as 'Painless' as possible. They went onto tell us that the person often became anxious at night so staff sat with them during these times and provided gentle re-assurance. This demonstrated a compassionate person centred approach to people's care.

We saw that some people who lived at the home displayed behaviours that challenged. We saw staff dealt with these sometimes difficult situations in a calm and professional manner. When people became agitated or distressed staff intervened with patience and compassion and used distraction and re-direction techniques to help diffuse the situation. This showed us that staff knew how to respond appropriately to people's needs in a way that supported them emotionally.

During the day staff responded to people's needs promptly and although often busy, took the time to chat to people whilst they were working. This promoted a social and homely atmosphere. We saw that staff ensured people's privacy and dignity was maintained throughout the day. We found however that one of the communal toilets on the ground floor did not have a lock on the door for people to use to preserve their privacy. This needed to be addressed.

Requires Improvement

Is the service responsive?

Our findings

The three care files we looked at, all contained person centred information about the person's needs and preferences and care plans and risk assessments were specific to the individual. This was good practice and ensured staff had clear guidance on how to provide person centred care. Staff spoken with, spoke warmly about the people they cared for and were able to tell us about people's likes and dislikes.

Care files included information about people's personal life histories. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia.

Care plans contained some good information on how the person expressed pain and distress so that staff could recognise the signs of emotional upset and respond accordingly. Where people had mental health conditions that sometimes meant they displayed behaviours that challenged, anxiety and/or confusion, there were risk assessments were in place to help staff manage these behaviours in a person centred way. Risk management advice gave staff simple person centred guidance on how best to person to support them when this situation occurred.

Staff were observed to support people in a person centred way. It was clear from what we saw that staff understood the person they were caring for and knew how best to support them in accordance with their wishes.

During our visit, we saw that a member of the care team was also employed as the activities co-ordinator. During our visit, a sing-a-long took place and a quiz. Another member of staff also took a couple of people out for a game of bingo, in their own time. There was a varied list of activities displayed on the noticeboard in the entrance area of the home. Outing such as trips out to the local cinema, market, local art gallery, New Brighton and a pub lunch were all advertised. People also had the opportunity to participate in activities such as a poetry group, garden party, reminiscence, zoo lab (live animal workshop), skittles and outside entertainers such as singers. The activities co-ordinator told us that they were in the process of contacting Everton Football Club for one of the people who lived at the home to see if a visit could be organised. The activities on offer assured us that the provider took people's emotional and social needs into account in the delivery of the service.

The provider had a complaint policy in place but the procedure was not clear in terms of who people should contact in the event of a complaint. The policy directed people to the manager and the provider but did not provide contact details for either party. There was no reference or contact details provided for the Local Authority Complaints Department or the Local Government Ombudsman to whom people can refer their complaints and reference to the Care Quality Commission's role in dealing with complaints was misleading. The Care Quality Commission welcomes and encourages people to share positive and negative experiences of care but has no legal powers to investigate individual complaints about service providers. This

responsibility lies with the Local Authority funding the person's care. This policy required clarification for people to have clear information on how to make a complaint.

The manager told us they had received no written complaints. People we spoke with said they had no complaints about their care and were happy with the care they received. Shortly after our visit, we received a complaint about the provider and the way in which concerns about their relative's care had been responded to. When we looked at how the provider had responded to the complainant we found that the provider had not worded their response in a compassionate and appropriate manner. This was a breach of Regulation 16 as the provider did not have an effective system in place to ensure complaints were handled and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

We looked at the systems the manager and provider had in place to monitor the quality and safety of the service. We found improvements were required.

For example, despite concerns being reported to the provider by the Local Authority, the manager and provider failed to have an effective system in place to monitor and address inappropriate moving and handling techniques used by staff. During our visit, the use of inappropriate techniques was commonplace. Staff supervision and observations of care failed to identify and address the risks posed by these techniques to people's health, safety and welfare.

During our visit we looked at a range of safeguarding and accident and incident records. Only some of the safeguarding and notifiable accident/incidents had been reported to the Care Quality Commission in accordance legal requirements. This meant the management system in place to ensure notifiable incidents were fully reported were not effective.

Safeguarding records were found in people's care files, which meant they were accessible to unauthorised staff. This compromised people's right to confidentiality and potentially placed people at further risk. We asked the manager to remove these records immediately.

We looked at the provider's medication audits and saw that they were relatively meaningless. The audit simply stated what medication was checked. It did not detail what had been audited for example, quantity in stock, expiry dates, staff signatures and did not identify whether any discrepancies or errors were found. On the day of our visit, we found stock discrepancies and a disorganised process for booking in and accounting for the medication received into the home.

Some policies and procedures were not adhered to or were unclear. For example, in the case of PRN medication, the medication policy stated "the precise time of giving the medication and the quantity of medication administered should be recorded. When we looked at the medication administration records staff had not done this consistently.

There was no management system in place to monitor the supervision and appraisal of staff. For example, there was no information retained by the manager as to which staff members had received supervision and appraisal at any given time. This meant it was impossible tell which staff members had received adequate support in their job role. We also found, the way in which staff were supervised and appraised, did not correspond with the provider's policy.

These examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because although some audit systems were in place they were insufficient and were not used effectively to assess, monitor and mitigate the risks to people's health, safety and welfare.

We saw a good range of environmental and maintenance audits that ensured the structure and equipment

used in the home was safe and in good working order. For example, audits of nurse call bells, fire doors and bath hoist checks.

There were systems in place to manage the risks of infection. For example, cleaning rotas and safety checks for wheelchairs and mobility equipment, the assisted bath, bed mattresses and the home's furnishing such as curtains were all in place and regularly undertaken. An infection control audit completed by the manager in August 2016 showed that the home had scored well in ensuring the risk of cross infection was managed.

Accident and incident audits were in place and recorded the action taken to protect people from further risk. A regular falls audit ensured people were referred to the Falls Prevention Team in a timely manner as and when required. This ensured people received the support they needed.

During our visit we found the culture of the home to be open and warm. Staff had a positive, can do attitude. They were friendly, welcoming and were observed to have good relations with each other and a kind approach to people's care. We saw that care was person centred and that people looked relaxed and comfortable in the company of staff. This aspect of service delivery showed elements of good leadership.

We saw that questionnaires seeking feedback from people who lived at the home, relatives and other representatives on the quality of the service provided had been sent out in June 2016. We reviewed a sample of the questionnaires returned and saw that positive feedback was received. One relative had commented "We are so grateful to you for the way you look after mum".

At the end of our visit, we gave feedback to the manager, deputy manager and provider. We discussed some of the concerns we had identified during our visit. We found them to be open and receptive to our feedback with a positive commitment to continuous improvement.

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 The provider had not ensured risks to people's health, safety and welfare were appropriately addressed. Regulation 12(1), 12(2)(a) and (b). There were no suitable systems in place to ensure the safe management of medication. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had no effective systems in place to ensure complaints were received, handled and responded to appropriately. Regulation 16(1) and 16(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had insufficient systems in place to assess, monitor and mitigate risks to the health, safety and welfare of service users. Regulation 17(1) and 17(2)(b).