Macleod Pinsent Care Homes Ltd

# Carlton House

## 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

We inspected Carlton House on the 8 and the 12 September 2016. Carlton House provides care and support for up to 25 older people. On the days of the inspection, 22 people were living at the service. Carlton House provides support for people living with varying stages of dementia along with healthcare needs such as diabetes and sensory impairment.

Accommodation was provided over four floors with a lift and stair lift connecting all floors. Four rooms were double occupancy rooms and two people had agreed to sharing one of these rooms.

The registered manager had left the service at the end of June 2016 and the service was being managed by the area manager who is referred to as 'the manager' throughout the report. 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.

People told us they were happy with the arrangements in place for the administration of medicines, however we found medicines were not always managed safely. Some medicines were out of date and staff did not always have guidance to follow for under what circumstances they would administer 'as and when needed' medicines to people. Medication administration records (MAR) were not always accurately completed.

Staff received an induction to the service before they worked unsupervised and completed training in subjects the provider considered mandatory, such as safeguarding adults at risk and moving and handling. However staff had not always received the refresher training they needed to make sure they were aware of current good practice guidelines. Staff had not always had the opportunity to meet with their line manager on a regular basis to discuss their training and development needs.

There was a complaints policy and procedure in place and people felt any complaints they may need to make would be taken seriously. However, complaints had not always been responded to within the providers own timescales.

Not all the records relating to the delivery of peoples care and the management of the service were up to date, accurate and complete. Therefore, the provider was not able to monitor these areas of practice to ensure that the care delivered was effective.

The providers' quality assurance processes had not been consistently applied and shortfalls identified as part of this process had not always been rectified within the timescales the provider had set.

At the last inspection in January 2015 not all staff had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were not consistently recorded in line with legal requirements. We

also identified that care plans were not regularly reviewed and the provider had no mechanism in place to assess the effectiveness of care plans. These were areas of practice we identified that needed to improve. At this inspection we found improvements had been made and these issues had been addressed.

People's care plans outlined their needs and the support required to meet those needs. Care plans were personalised and included information on people's individual likes, dislikes, daily routine and what was important to them. One person's visitors told us "We are very happy, very pleased they are here, we think they're safe and that gives us peace of mine".

People had the opportunity to take part in activities they enjoyed and were meaningful to them. Staff regularly took people out to local shops, cafes and for walks. People's religious and cultural needs were maintained and supported, and the home had built links with the local church community.

People were treated with respect and dignity by staff. They were spoken with and supported in a sensitive, respectful and caring manner. One person told us "The staff are lovely, they are always very kind".

People told us they enjoyed the food. Risks of malnutrition and dehydration were identified and managed effectively and people were supported to have enough to eat and drink. Referrals to health care services were made quickly when people's health needs changed and staff sought advice from health care professionals in how to support people to remain in good health.

People were able to personalise their rooms with their own belongings to help them feel at home. The lounges were domestic in character and gave the service a 'homely feel'. One person's visitors told us "They brought all (person's name) pictures and belongings and put them in the room ready".

Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected. One staff member commented "Any unkindness is unacceptable, I would report to a senior, or if necessary go to the owners or whistle blow". Sufficient numbers of staff had been deployed to meet peoples assessed needs. Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

Staff spoke positively of the manager and felt they were providing good leadership. The manager was aware of the majority of the shortfalls we identified and already had a plan in place outlining the action they were going to take to rectify them.

There are a number of areas where the provider was not meeting the requirements of the law. You can see what action we have asked the provider to take at the back of the full version of this 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 consistently safe.

The management of medicines was not consistently safe. Some medicines were out of date, the stocks of some medicines did not balance with the records, and medication administration records had not always been completed accurately.

Suspected abuse had been reported to the local authority in line with local protocol and staff had received training in protecting adults at risk.

Risks to people's safety had been identified and measures were put in place to reduce these risks as far as possible.

Recruitment practices were robust and staff were deployed sufficiently to deliver safe care.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff had not always received the training and support they needed to carry out their role and meet people's needs effectively.

People were supported to access healthcare support when needed.

Staff had a good understanding of the MCA and worked in accordance with legal requirements.

People's nutritional needs were met and people could choose what to eat and drink on a daily basis.

### Is the service caring?

**Good**

The service was caring.

Staff had a good understanding of people's needs and treated people with kindness and dignity.

People's privacy and confidentiality were respected.

People and their relatives were involved in decisions about their care and treatment.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's complaints had not always been investigated and responded to promptly.

Plans were in place to ensure that people received care that was personalised to meet their needs and wishes.

People had the opportunity to take part in activities that they enjoyed.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

The home's quality assurance framework had not been consistently applied and shortfalls identified had not all been addressed within the timescales set by the provider.

Records were not always up to date and accurate.

People spoke highly of the manager and staff.

The provider was aware of their legal responsibilities.

# Carlton House

**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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 8 and 12 September 2016. This was an unannounced inspection. The inspection team consisted of two inspectors.

Before the inspection we reviewed information we held about the service including previous inspection reports, any notifications (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We looked at areas of the building, including people's bedrooms, the kitchens, bathrooms, and communal lounges. Some people were unable to talk to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection, we spoke with six people who lived at the home, five visiting relatives, 10 members of staff including the registered manager, four care staff, the chef, the housekeeper, the laundry assistant, the maintenance person and the administrator. We also reviewed the records of the home. These included four staff recruitment files, staff training records, medication records, accidents and incident records, the providers quality assurance systems, and the complaints folder. We looked at six care plans and risk assessments along with other records relating to the delivery of care such as food and fluid charts and daily records. We also 'pathway tracked' people living at the service. This is when we looked at their care documentation in depth and obtained their views on how they found living at the service.

Requires Improvement

# Is the service safe?

## Our findings

People and their visitors told us they felt people were safe. One person's relative told us "Yes I think she is safe here". Another person's visitors told us "We are very happy, very pleased they are here, we think they're safe and that gives us peace of mine".

Medicines were not consistently managed safely. People told us they received their medicines on time and visiting relatives felt assured that care staff managed their relative's medicines well. Some people had been prescribed medicines on an 'as and when needed' basis for example pain relieving medicines and medicines to relive the symptoms of anxiety. These medicines should only be offered to people under specific circumstances and when specific symptoms are exhibited. Good practice is that staff should be provided with specific guidance as to what these circumstances and symptoms are, the steps they should take before giving the medicine, and for how long the medicines should be administered before they contact the prescriber for further advice. However, this guidance was not always in the place for staff to follow and the reason why some of these medicines had been administered to people had not always been recorded on the Medication Administration Records (MAR). MARs are documents to record when people receive their medicines. Therefore the provider was not able to monitor the effectiveness of these medicines, or be assured they had been administered for the reasons they had been prescribed and intended.

Medicines were ordered in a timely manner and stored securely. The majority of medicines were received in blisters which contained most of the medicines each person had been prescribed for set times of the day. We did not identify any problems in relation to the recording, administration or stocks of these medicines. However, we found some 'as and when needed' and other medicines not contained in the blister medicines were out of date and some others did not have an expiry date. Therefore the provider could not be assured these medicines were stills safe to use. The balance of the quantity of these medicines in stock had not been entered on the MAR, therefore it was difficult for staff to check whether the stocks of medicines were correct. We completed a spot check on some medicines and found that some did not balance with the amount that had been received, less the amount that was recorded as having been administered. Therefore, the provider could not be assured whether or not these medicines had been administered to people or not.

Staff training files evidenced that staff that administered medication had undergone the relevant training and regular updates. However, there were no records to evidence that medication competency assessments had been carried out to assess whether these staff were safe to handle and administer medication. One staff member said that the last time they had received an assessment was, "about three years ago". It is important that staff complete refresher training on a regular basis so that they stay up to date with good practice guidelines.

The provider had not ensured the administration and management of medicines was always safe. This is a breach on Regulation 12 of the Health and Social Care Act 2014.

Staff were able to give examples of different forms of abuse. They were able to describe to us the action they would take if they suspected abuse had been taken place. One member of staff told us "If I was concerned

about anything I would report it to the senior on duty or to the manager. I would then want to know what had been done about it". Another told us "If I see or hear anything that is not right I must report it to my manager or to a senior. If I was still not happy I would whistle blow to social services or the CQC". A third told us "Any safeguarding issues, I would report to senior management and if it wasn't dealt with I would whistle blow to CQC. The number is in the safeguarding folder". Most staff had completed training in safeguarding adults, however some of the training certificates were no longer valid and refresher training was overdue. The manager told us and records confirmed that this training had been booked.

There were processes in place to identify risk and minimise harm occurring. Care plans contained risk assessments and risk management plans, which included the risk of falls, nutritional assessments, tissue viability and environmental risks. We saw one person's records detailed number of falls had been documented. In response to this the person had been referred to their GP and to an occupational therapist, a risk management plan and extra safety equipment had been put in place and a 'post falls analysis' had been carried out. For each person living in the service there was an emergency evacuation plan in place (PEEPS). Staff were aware of the plans and the action they should take in the event of the home needing to be evacuated.

People were cared for in an environment that was safe. There were procedures in place for regular maintenance checks of equipment such as the stair lift, firefighting equipment, lift and moving and handling equipment (hoists). Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, staff safety and welfare.

The service was clean. Antiseptic hand cleaning gels were located throughout the home and staff had access to personal protection equipment (PPE) such as gloves and aprons. Training records we examined showed that staff had received infection control training and we observed staff wearing PPE when carrying out personal care tasks. Our observations were that some of the carpets in communal areas were ingrained dirt, and some of the bedroom carpets needed replacing. The manager told us that a programme of refurbishment was being undertaken, which included replacing some of the carpets and the deep cleaning of others.

Robust recruitment practices were in place when employing new staff. This included an application form, full employment history and evidence of a formal interview. Two references and a Disclosure and Barring service (DBS) were also gained before new staff began employment. Records showed that where staff from overseas were employed, the required documentation was in place to confirm they were entitled to work in this country. Staff confirmed that they had not commenced employment until all of the required documentation had been put in place.

Sufficient numbers of experienced staff were deployed. A team of three care staff, a senior carer, chef, cleaner and the manager were available throughout the day. Vacancies and staff leave were covered by staff taking on extra shifts, or by the use of agency staff that worked at the service on a regular basis. The night shift consisted of two care staff with the manager providing on-call support. We observed that people received care in a timely manner and call bells were answered promptly.

Requires Improvement

# Is the service effective?

## Our findings

People and visiting relatives spoke positively of the home and of staff members. All of the staff that demonstrated a good knowledge of the people they were supporting. They were aware of people's health care needs and were made aware of any changes to their needs at staff handover times. One person told us "I like the staff, they help me and my room is kept clean". Another person told us, "We have night staff, they are very nice people. We are very well cared for here." A relative commented "(Staff member's name) is very good, knows what she's doing. The others are good too, they cope really well".

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. We checked whether the service was working within the principles of the MCA.

At the last inspection in January 2015 staff's understanding of the Mental Capacity Act 2005 (MCA) was limited and not all staff had received MCA training. At this inspection we found improvements had been made. Staff had completed the training and had improved their knowledge and understanding of the MCA. Senior staff were very conversant with the processes and other staff were aware of the need to respect people's freedom of choice. Staff training records demonstrated that the majority staff had received MCA and Deprivation of Liberty Safeguards (DoLS) training and new staff had been booked to attend. One member of staff commented "If people have dementia and it is thought that they might not be able to make some choices for themselves, meetings have to be held with other people such as families and social services to make sure that they are not being unfairly restricted". Another member of staff told us "I am aware of the five principles and the need to assess an individual's capacity. There has to be the involvement of the family and other professionals and you must involve the resident at whatever level they can take part". A third staff member told us "For the safety of people we have a keypad on the door, but that does not mean that people can't make choices about other things in their lives like what they want to wear and to eat. One resident is not on a DoLS and goes out independently". Where people were unable to make decisions for themselves staff had considered the person's capacity under the Mental Capacity Act 2005, and had taken appropriate action to arrange meetings to make a decision within their best interests. Referrals had been made for DoLS and we could see that staff understood how these were implemented.

Systems to support and develop staff were in place through supervisions meetings, training and annual appraisals. Supervision meetings gave staff the opportunity to discuss their own personal and professional development, as well as any concerns they may have. Most staff told us they had not had supervision between the end of 2015 and the manager taking up post in June 2016. One staff member commented they had not had supervision "for about six months". Most staff had completed the training the provider considered to be mandatory, such as moving and handling, first aid and safeguarding adults. Many of the people living at the service were living with dementia. The training records indicated that of 20 care staff,

twelve had completed dementia awareness training. A number of people suffered from anxiety had mental healthcare needs and could at times become agitated and displayed verbal and or physical aggression. Four staff members had received training in how to support people who displayed this type of behaviour. The training records showed many of the training certificates were out of date and refresher training was overdue. The manager told us they had identified the gaps in staff training and the need for refresher training to be completed. The administrator confirmed they were booking staff onto training courses as they became available. Records we saw confirmed this. Whilst we did not assess that any harm had occurred as a result of the shortfalls in staff supervision and staff training, this is an area of practice we identified that needs to be improved and sustained.

When new staff commenced employment they were subject to a probationary period and completed an in-house induction. They then shadowed more experienced staff for at least three shifts before undertaking tasks alone. We were shown evidence that newly employed staff were undertaking the care certificate. The care certificate is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

People told us they enjoyed the food on offer. A variety of nutritious food and drink was provided and people could have snacks at any time. There were records of people's likes and dislikes in place and also information detailing the requirements for individual special diets, for example vegetarian or soft diets. The chef made fresh soup every day and there was always food in the fridge for snacks for people like to eat during the night. One person pushed their food away at lunch time. When the chef noticed this they offered the person a bowl of soup instead and the person replied "Yes please I love your soup, it's always delicious". We observed that staff were aware of who required their drinks to be thickened to reduce the risk of choking, and that they thickened them to the consistency advised by the Speech and Language Therapist (SALT).

Good

# Is the service caring?

## Our findings

People and their visitors told us they felt the staff were kind and caring and treated their loved ones with respect. One person told us "The staff are lovely, they are always very kind". Another person told us told us, "All the staff are so caring." A relative spoke highly of the staff and commented "All the staff are lovely" and "it has a nice family feel".

When observing staff practice we saw that relationships between staff and people were supportive and friendly. Staff were very kind in their approach and there were lots of smiles and positive interactions. A staff member commented, "I work here because I believe in what we do. It's hard work, especially working with people with dementia, but we all do really care".

We observed one person being assisted with lunch in bed. The staff member ensured the person was in a comfortable position; they were very gentle and kind and did not rush the person. The staff member explained to the person what they were eating and asked if it was alright to regularly wipe the person's face. The person was offered regular drinks and the staff member kept chatting and smiling. The person did not speak at all, but smiled back at the staff member and shook their head when they had eaten enough. The staff member encouraged the person to eat, but respected the person's choice when they did not want any more.

Staff were also very knowledgeable about the needs of the people they were supporting. An example of this was that for the whole of the visit, one person was showing signs of distress and was constantly asking staff when they could go home and when their family was coming to get them. Each member of staff including the maintenance person and the cleaner was aware of how to respond to this individual when they became distressed. We saw they were very patient and diverted the person or made a coffee for them. Each time staff responded in this way it alleviated the person's distress and they became relaxed.

People were supported to be independent and take part in activities of daily living. One person's records stated that to support their mental health and behavioural needs the person 'Needs to spend time constructively and should be offered the opportunity for helping with laundry, folding and putting it away'. Although we did not observe this happening staff confirmed to us that they and other people did participate in this activity as well as helping to lay the table at meal times. People who wished were supported to attend a local church every Sunday. Staff told us the church community picked up people and escorted them to Church every week. Ministers, Reverends and Priests also visited the home providing services for people who may not be able to attend the local service.

Considerable thought had been used when designing the environment to promote people's wellbeing and help them feel at home. The communal lounges were domestic in character and sofas and chairs were arranged around was in place around a fire place. A dining table was at the back of the lounge, with armchairs for people to look out at the garden. Books, videos and DVDs were displayed on the lounge wall for people to use. Rummage boxes (boxes with items from the past, or items such as sewing equipment) were available for people to spend time going through them. Stimulation was consistently around the home

with objects and things for people to pick up and do. People could access the garden which was secure and some people liked to help doing gardening.

People's bedrooms were personalised and had pictures of how they recognised themselves to help orient them and walk around the home independently. Signs were displayed in colour with pictures throughout the home, such as signs for the toilet, lounge and dining room to help them find their way.

People had been supported to maintain their personal and physical appearance, and were dressed in the clothes they preferred and in the way they wanted. Ladies that wanted to had their handbags and wore their jewellery and make up. A hairdresser visited the home on a regular basis.

People's privacy was respected and they were treated with respect. Staff knocked on people's doors and waiting for a response before answering and doors were kept shut when delivering personal care. Records were stored securely.

Requires Improvement

# Is the service responsive?

## Our findings

People and their visiting relatives felt confident in raising any concerns or complaints. The complaints policy was displayed in the entrance to the home and in the resident handbook, which was provided to people and their relatives when they started using the service. However, records demonstrated that one complainant had written to both the registered manager and provider several times before getting a response. In addition to this there had been a delay of three months before the previous registered manager had responded to the complainant's last letter. The complainant told us they remained dissatisfied with the way their complaint had been handled. This is an area of practice that we identified as needing to improve.

The manager and staff had a firm understanding of person centred care and it was clear staff recognised each person in their own entity. From observing staff interaction, it was clear staff had spent time with each person getting to know them and had a good understanding of their likes and dislikes. Staff handovers were informative. They included a summary of how each person had spent their time, how they were feeling, whether they had slept well and eaten well and whether they had anything planned for the rest of the day. They also included any changes to people's health care needs and whether there had been any changes to people's medicines and whether anyone had been prescribed short courses of medicines such as antibiotics

Each person had a care plan in place. Care plans showed that people's individual needs and wishes were assessed and recorded prior to them being admitted to the service. We saw that where relevant, people's families and other professionals involved in their care had been consulted and involved in the process. Each section of the care plan was relevant to the person and their needs. They detailed a short life history, likes and dislikes and preferences for routines. They were completed on an electronic system and backed up by paper folders and reviewed on a monthly basis. We saw one person had a behaviour management plan in place. This had been implemented following advice given by the local dementia 'In reach team' and the dementia liaison nurses. This gave staff direction as to how to support the person if they became agitated and strategies to use to distract them and de-escalate situations. However, behaviour plans were not in place for everyone who could display this type of behaviour and some people's care plans had not been reviewed or updated to reflect their current care needs. The manager acknowledged this and told us they had identified this as an area they needed to improve on. They showed us an action plan they had implemented following an audit they had completed in July, which highlighted 'information is sporadic and does not accurately reflect the needs of the residents' the action plan stated 'a complete overhaul of care plans needed' another action was to 'Archive unnecessary documentation'. The managers' action plan stated these actions needed to be completed by the end of October. Whilst we did not assess any harm had occurred as a result of these shortfalls it is an area of practice we identified as needing to improve and become embedded into day to day practice.

Visiting relatives confirmed they were involved in the formation of the initial care plans and were subsequently asked if they would like to be involved in any care plan reviews. One person's relative commented "I've been involved in care planning in the past and I'm always informed if something happens". Another visitor told us the person they were visiting had lived at one of the provider's other services before moving into Carlton House. They told us "The transition was smooth. There was good continuity. They

brought all (person's name) pictures and belongings and put them in the room ready. They staff are very informative when we ask anything and always let us know if anything is wrong".

People could choose what time to go to bed and get up, what to wear and how to spend their time. Our observations were that people got up and ate their breakfast at different times as they wished and that staff responded to people's requests for assistance in a timely manner.

People were supported to maintain good health and received on-going healthcare support. People commented they regularly saw the GP and visiting relatives felt staff were effective in responding to people's changing needs. Care records confirmed that where staff had concerns, referrals had been made to health care professionals such as the GP, district nurses, SALT and chiropody services.

There were a range of activities available to people to take part in detailed on an activities programme. These included going out for walks and quizzes. One person was supported to go to church on Sundays and another was independent and accessed the community themselves. People also went out with their families and friends. During the first day, we noted that one person had their nails painted. On the second day we saw the activities organiser supported people to go out for walks and one person to go to the post office. The manager told us, and records confirmed that outside entertainers and a 'pat dog' also occasionally visited the home. People's daily records confirmed they participated in a range of structured activities and impromptu activities that interested them, for example one person's records stated 'Took (person's name) out to the sea front for an ice cream'. Another stated 'In the afternoon (person's name) was making cookies which they enjoyed' and a further stated 'came downstairs to the front lounge and took part in a crossword'. One visitor told us how the manager had arranged to take one person to an exhibition at the Brighton Fringe festival which was of interest to them. They explained the person was not well on the day, so did not attend, but the visitors were impressed with the fact that staff had "recognised their past" and "made the effort".

Requires Improvement

# Is the service well-led?

## Our findings

People, relatives and staff spoke highly of the manager. One relative told us they felt things had improved in recent months since the area manager had started to manage the service on a day to day basis. Staff told us they felt they had more direction and leadership. They told us they knew there were a lot of improvements to make, but felt the manager was starting to make a difference. One member of staff commented "We have been going through a bit of an upheaval with no manager, but (manager's name) is very supportive and there whenever you need assistance or advice". Another staff member told us "I think the carers are fantastic with residents, but our paperwork is not so good". A third staff member told us "The manager is very good, she is supportive and trying to improve things, we know we have fallen behind, but she will listen and help and if needed will be hands on". Despite people's high praise for management, we found Carlton House had not been consistently well-led and improvements were needed.

Records had not always been accurately completed; for example food and fluid charts had not always been completed or totalled, so the provider had no way of monitoring whether the food and fluid intake for these people was sufficient. Records of room temperatures which the provider stated should be completed by staff twice daily when the weather was hot had been completed sporadically, and there was no indication of how these records were being monitored or audited. Most daily notes were repetitive and task oriented and gave little information on how the emotional needs of people were being met or how they were supported other than for personal care. The activities book recorded which people had been present for activities, but did not specify what the activity was, who had taken part or the quality of the interactions. Therefore, the provider was not able to monitor these aspects of the service and assess whether the care delivered was effective.

The provider had not ensured that the records relating to the management of the service were always up to date accurate and complete. This is a breach of regulation 17 of the Health and Social Care Act 2014.

At the last inspection the provider did not have a system in place for auditing the content and effectiveness of people's care plans. At this inspection we found that these audits had been introduced. The provider also had systems in place to monitor the running of the service and the effectiveness of systems in place. These included welfare monitoring checks, health and safety audits, office inspection checks, health and safety monitoring and emergency procedure checklist. They told us that the provider had identified that previous audits had not always been completed accurately, some of the actions had not been completed within the timescales that had been set and some had not been completed at all. As a result of this, in April 2016 the provider had set an action plan specifying what action they needed to take and by when. The manager told us since taking over managing the service after the registered manager left at the end of June; they had identified further shortfalls in the records. They showed us a report they had completed for the provider highlighting areas they had identified as needing to improve and had implemented an action plan they were working through. This report and action plan demonstrated that the manager had already identified the need for regular staff supervision, the need for staff to complete more training and for care plans to be updated. It also identified that the results of satisfaction surveys, which had been sent to people and their relatives to complete, needed to be analysed and the results used to identify areas for improvement.

Additionally, that staff needed further training and guidance on record keeping. Whilst we did not assess that any harm had occurred as a result of the fact that the provider's quality assurance audits were not completed accurately, it is an area of practice we identified as needing improvement.

At our last inspection in January 2015 improvements were needed to be made in relation to the monitoring of incidents and accidents to ensure they were consistently analysed and reviewed to identify any on-going themes, trends or patterns. At this inspection we found that the accident and incident records had been monitored, analysed and reviewed, and appropriate action had been taken to reduce the risk of reoccurrence. For example, referrals had been made to the relevant health care professionals for one person who had fallen on a number of occasions. Another person who had been involved in a number of accidents and incidents had been reassessed as requiring nursing care.

Staff felt the manager was approachable and supportive. One staff member told us "They have been very supportive to me especially when I had a family crisis". Staff described an 'open door' management approach were they were encouraged to ask questions, make suggestions and address problems or concerns. Although there had been a period of time when team meetings had not been held on a regular basis, these had been reintroduced and the minutes of these meetings demonstrated that staff had the opportunity to raise issues and make suggestions.

The manager was visible in the service and took an interest in people. The service had a strong emphasis on team work and communication sharing. Staff commented they worked well together and communicated effectively. Staff told us they would have no hesitation in raising concerns with the manager, or externally if they had any concerns about poor practice. All staff were aware of the providers whistle blowing policy and one staff member commented "Any unkindness is unacceptable, I would report to a senior or if necessary go to the owners or whistle blow".

The manager had a firm understanding of their responsibilities informed the commission of notifiable events. The rating from the last inspection was displayed in the service and on the provider's webs site as is required by law. They had links with the local dementia in reach team and worked closely with the providers other managers with whom they discussed and shared good practice.

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<br><br>12(1)(2)(g) The registered person had not ensured the proper and safe management of medicines. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>17(1) (2)(c) The registered person had not ensured an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided, had been maintained. |