Larchwood Care Homes (North) Limited

Alwoodleigh

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

The inspection took place on 10 and 20 January 2017 and was unannounced. The service had previously been inspected in March 2016 and was found to be in breach of the Health and Social Care Act 2008 Regulations in relation to record keeping, safe care and treatment, consent and good governance. The overall rating for this service was 'Inadequate' and the service was placed in 'Special measures'. This inspection was to check that improvements had been made and the service could sustain improvements.

Alwoodleigh is registered to provide nursing and personal care for up to 40 people. There were 34 people staying there at the time of our inspection. The home provides support for older people some of whom are living with dementia. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The nursing unit is based on the upper floor and the residential unit on the ground floor.

There was a manager in post on the day of our inspection who was in the process of registering with the Care Quality Commission. 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.

At our previous inspection we found there had not been enough staff to meet the needs of the people at the home. There was now a system in place for determining staffing levels and there were sufficient numbers of staff at the service on the days of inspection to meet the needs of the people at the home in a timely way.

All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They were confident their concerns would be acted upon.

The ordering, storing and administration of medicines was safe. Staff had had an annual medication management competency check and regular audits were undertaken. There was an issue with a person receiving their medicines without their knowledge hidden in a drink but this had been resolved by the second day of inspection.

We found personal emergency evacuation plans in place, although equipment people required was not included on this information. Standardised risk assessments were in place around pressure sores and nutrition and these were regularly reviewed. We found a lack of recorded information regarding assessments for assistive equipment and moving and handling care plans lacked the method and a description of the equipment to be used. This meant a safe system of work had not always been clearly recorded.

We found the environment to be clean and we observed good infection control practices in place. There was a programme in place for replacing carpets where malodours were present and could not be removed by

carpet cleaning.

The registered provider supported staff to develop by offering mandatory training courses and enabling staff to undertake e-learning whilst on shift. Staff received supervision to help them develop into their roles and all new staff received an induction into the service and shadowing opportunities.

Staff had received training in assessing mental capacity or the Deprivation of Liberty Safeguards. However, we found decision specific capacity assessments had not always been undertaken and capacity assessments had not led to recorded best interest decisions, when a person had been assessed as lacking capacity. Staff were able to advise us how they would act in the person's best interests whilst providing care. We found consent for care and treatment was recorded in some care plans but not in all the care plans we reviewed and decisions made on behalf of people who lacked capcity were not in line with the requirements of the Mental Capacity Act 2005.

People told us how much they enjoyed the food. We saw people being supported with their food and drink. However, the recording of what some people had eaten and drank was not always detailed and although staff could tell us exactly what people had eaten this was not always reflected in the records.

Staff protected people's privacy during personal care delivery and were kind and polite to people during our inspection.

There had been an improvement in the activities on offer to people at the home and an enthusiastic activities coordinator had been employed who was developing the programme to ensure they were offering activities which met the choice and preference of the people at the home.

We found the quality of care plans was mixed with some very personalised information. Other care plans had been difficult to navigate due to the quantity of information which was not always current. The registered provider was in the process of transferring these over to their new paperwork.

The manager and regional manager were working together to improve the quality of the service provided. They were actively trying to recruit staff with the knowledge and skills to support a high quality service.

Not all audits were identifying issues which needed to be addressed such as care plan audits to ensure care records were to a high standard.

Regular meetings were held to keep people at the service, their relatives and staff informed about what was going on at the home.

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.

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Risks had not always been assessed and recorded and moving and handling care plans lacked information about the method for staff to follow and equipment to be used.

The ordering, storing and administration of medicines was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

We found a lack of compliance with the Mental Capacity Act 2005 and capacity assessments did not follow the correct process. We found a lack of evidence of recorded best interest decisions.

Some care records evidenced people had consented to their care and treatment. But for those who lacked capacity the correct procedure had not been followed and the registered provider did not have a record of who might be able to consent on a person's behalf through a Lasting Power of Attorney.

People told us they enjoyed the food at the service and the dining room was set up to maximise the dining experience for people at the home.

Is the service caring?

Good

The service was caring.

We observed some very kind, caring and compassionate interactions on the day of our inspection.

Staff were observant in protecting people's privacy during personal care provision.

Staff encouraged people to remain independent with activities of daily living and mobility.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in the process of being updated but on the day of inspection, some of the care plans were difficult to navigate due to the amount of information which was not always current.

The activities coordinator was enthusiastic and encouraged people to take part in activities that were meaningful to them as individuals.

Complaints were not always recognised or recorded although all the people we spoke with told us they knew who to report complaints to and were confident these would be acted upon.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a new manager in post who was in the process of registering with the Care Quality Commission. They were supported by a regional manager and together were making improvements at the home.

Some audits had not been robust to rectify issues we found at inspection such as with mental capacity assessments, equipment and moving and handling documentation.

Systems and processes were being implemented which require time to embed to sustain improvements at the home

Alwoodleigh

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 10 and 20 January 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors 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.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. Before our inspection, we reviewed the information we held about the home. We reviewed all the intelligence we had about the service including the statutory notifications, enquiries and safeguarding referrals. We contacted the commissioners of the service and the local authority safeguarding team. We also contacted Healthwatch who sent us the most recent "Enter and View" visit they had undertaken in 2014. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We observed the breakfast and lunchtime experience in the dining room in the residential unit. We spoke with ten people who lived at Alwoodleigh Care Home. Six were living on the ground floor in the residential area and four on the first floor in the nursing area. We also spoke with four people who were visiting relatives. We observed people supported in the lounge areas on both floors.

We spoke with the manager, the regional manager, a nurse, two carers, the cook, and the activities coordinator. We also spoke with a visiting dietician during our inspection and a fire officer following our

inspection. We reviewed six people's care records and the records relating to environment and maintenance checks.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at Alwoodleigh whether they felt safe. We received the following comments, "Oh yes most certainly, they are looking after me very well here" and "I feel very safe, no complaints at all". One person said, "Ooh yes I do feel safe, it's like home, it's lovely and it's restful". One relative told us, "I am here six days each week." They told us they were confident their relation was safe at Alwoodleigh.

At our previous inspection we found there were not enough staff on duty to meet the assessed support needs of people living there. At this inspection we found improvements had been made in relation to staffing levels. The service had a dependency tool in place to determine the number of staff to meet the needs of the people at the home which the manager explained to us to confirm they had the appropriate level of staffing.

We asked people at the home whether there were enough staff to meet their needs. They all told us there were sufficient and they usually attended to their needs in a timely manner and were attentive. There were two exceptions to this. One person said "They are usually very good but there was an occasion where I was left sitting on the loo for twenty minutes which is very frustrating". Another person said "I think there are enough staff in the day but not at night. It can often be eleven, twelve o'clock when I get my medicines. It was once one o'clock when an agency nurse was working". We mentioned this to the registered provider who agreed to verify the accuracy of these statements.

We asked staff about their understanding of safeguarding. They demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. They were able to give examples of how they would identify abuse. Staff also knew the principles of whistleblowing and assured us they would not hesitate to report any concerns. The manager told us safeguarding training was provided as part of staff induction but was also talked about in supervision and staff meetings.

At the previous inspection we found missing risk assessments for identified risks such as around the use of assistive equipment and not every file we reviewed had detailed moving and handling risk assessments and care plans. At this inspection although some improvements had been made, the moving and handling risk assessments and care plans were basic and did not describe the method for staff to follow. In one file it referred to a shower chair to be used for the person, but when we asked to see the shower chair, we were told this person did not have a shower chair and did not use the shower. Nor did their file detail how staff were to move them out of their bed. In another file, the person had come to live at Alwoodleigh three days before the inspection and required assistance of equipment to be moved, but there was no moving and handling care plan in place. This meant staff were moving and handling people without clear guidance and although we did not evidence any poor practice during our inspection, the service was not able to evidence it had complied with the legal requirements to ensure the safe moving of people.

We found risk around the use of assistive equipment had not been assessed. For example, people using assistive equipment such as specialist chairs, shower chairs, the assisted baths, and wheelchairs did not

always have an assessment in their care files or instruction for staff on how to use the equipment or move the person in the equipment.

There were personal evacuation plans (PEEPS) to guide staff how to support individual people in the event of an emergency. These were basic and contained information such as "2 carers required, hoist, sling and wheelchair" as opposed to details of the assessed sling, hoist or wheelchair to ensure the incorrect equipment was not accidently used. The registered provider undertook a six monthly check on its fire resisting structure. Staff explained to us the procedure they would follow in the event of a fire. We spoke with the Fire Service following our inspection who advised us the home had complied with issues they had found at their last inspection, but they would be revisit to ensure the home continued to meet their obligations.

We looked at four staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) checks, reviews of people's employment history and that two references had been received for each person. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

We looked to see how the service was managing people's medicines including the ordering, storing and administering of medicines. Medicines were stored in a designated medicines room, which was clean and tidy. We saw there was a board on the wall, with the names for those people requiring early morning medicines. There was a list of staff signatures to provide a record of which staff administered medicines. We also found consistent monitoring of the room and drug fridge temperatures.

During our visit to the home the senior carer was observed completing a scheduled medication round. We observed they administered medicines to people sensitively and discreetly. They asked people whether they had any pain that required pain relief. They had a system in place to ensure they were systematic in their administration to ensure medicines were not missed. We saw evidence that staff had had an annual medication management competency check.

Each person had a Medicines Administration Record (MAR) chart which contained the person's details, an ID photograph and whether they had an allergy to medicines. We saw protocols for "as required" medication were in place. Creams were dated on opening to ensure they were used within the manufacturer's time frame.

We asked staff whether anyone was administered covert medicines (administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them). We were told one person had medicines administered covertly on the instructions of the GP, and these were crushed in Coca-Cola. As we found no record of a capacity assessment or an indication this person lacked capacity in relation to consenting to medicines, we questioned the legality of this with the manager. By the second day of our inspection the GP had revisited and determined the person had capacity to refuse their medicines, and understood the consequences of making an unwise decision and was exercising their right to withhold consent. In addition, there was no record the home had checked with the pharmacy whether the medicines could be safely crushed and dissolved in Coca-Cola.

These examples demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed accidents and incidents were recorded and the manager undertook an analysis of

accidents. They told us they referred onto the falls prevention team where a person had been identified as falling frequently and we saw evidence to confirm this.

We observed the home was clean and staff had access to plentiful supplies of protective aprons and gloves. There was an odorous smell in parts of the home which we raised with the manager. They told us they were in the process of replacing some of the carpets which although were regularly cleaned, they found impossible to remove the malodour and therefore, the flooring was to be replaced.

Requires Improvement

Is the service effective?

Our findings

All the people we spoke with said the meals were good with a choice of two hot dishes at lunchtime followed by a dessert of pudding, ice cream or yogurt. Sandwiches were served at teatime with a second alternative such as a crumpet. This was followed by a dessert, ice cream or yogurt. Comments from people living at Alwoodleigh included, "The food is smashing here, they've a good cook but there's not much choice, they will make you something if you don't like what there is", and "The food here is beautiful. We have fish on a Friday which is smashing. There's always plenty of fruit and vegetables". One person told us, "The food is very good; I've put on weight since I came here. I would like to see other alternatives at teatime like salads, it's always sandwiches. I think there is still room for improvement. You can have snacks in between meals but the meals are so good I don't need them". Another person said, "The food here is very good, Christmas dinner was marvellous. There's always plenty to eat and drink during the day. They come with drinks and biscuits morning and afternoon. "

We observed the dining experience in the main communal dining room on the ground floor. Tables were laid with table cloths and condiments. As each person came into the dining area at staggered intervals they were asked where they would like to sit. People had been offered a choice of menu by the cook earlier in the day. Meals were placed in front of people without staff advising them what they had chosen, albeit there was a menu displayed in the dining room.

There was a small dining room on the second floor which was used by three people on the second day of inspection, as most people ate in their room. We saw people being supported with their food and drink. A number of people had their food and drink monitored and most records were accurate in relation to people's food and fluid charts matching their daily records. However, in one of the records we reviewed the food chart did not detail the exact amount the person had eaten nor did the daily record. Staff could tell us exactly what the person had eaten but without a record of this, it would be difficult to keep an accurate account.

We asked the manager how new staff were supported to develop into their role. They told us new staff completed the Care Certificate as part of their induction and they were allowed 12 weeks to complete this, which was then signed off by their head office. They told us new staff were placed on the staff rota as extra staff for about a week to shadow more experienced staff which enabled them to settle into their new role. The manager sent us the training matrix to review following our inspection which showed that staff training was ongoing to ensure staff developed knowledge and skills to perform in their roles.
The staff we spoke to on the day of our inspection told us they regularly undertook e-learning and could do this as part of their shift. The manager told us certain staff had been identified to become 'train the trainers' so they could provide practical training for staff such as moving and handling and safeguarding training. Staff were currently undergoing care planning and record keeping training during our inspection process. Mandatory training included moving and handling theory and practical, safeguarding, Mental Capacity Act and DoLS and dementia awareness.

We saw evidence that staff had regular supervision. We reviewed the supervision records for four staff. The

staff supervision documents had not been completed fully and although they contained a record of the session there were gaps in areas such as training and development requirements and were more about addressing issues with staff such as around the cleaning of mattresses and recording practices. Staff annual appraisals were ongoing and had not been completed at the time of our inspection. The manager told us some of the staff had been given paperwork to complete for their appraisals which would be followed by the manager completing their section and a meeting with the appraisee.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had two authorisations in place and was waiting the outcome of a further seven requests they had made to the local authority for an authorisation.

The home applied the two stage capacity test to everyone at the service in relation to each aspect of their care delivery and deemed most people as having capacity to consent to care and welfare decisions. We found one person's assessment which deemed they lacked capacity to make decisions, but there was no best interest decision recorded to enable the care staff to determine it was in their best interests for staff to carry out the activity. We also found a two stage test for individual decisions for a person who lacked capacity but the test had deemed they had capacity, and therefore the home did not proceed to a best interest decision. Most of the staff had received training in assessing mental capacity or DoLS and were able to advise us how they would act in the person's best interests whilst providing care but it was clear from our review of records, that staff did not fully understand the principles of the act and how to record decisions made on behalf of people. There was also a lack of evidence the home had checked whether any family members had Lasting Power of Attorney in relation to health and welfare decisions, but the manager agreed to remedy this by checking this with people's relatives and asking them to bring a copy of the documentation for the person's records.

We found consent for care and treatment had been recorded in the new care plans where people had capacity although there was a lack of adherence to the Mental Capacity Act 2005 for those who lacked the capacity to consent to care and treatment. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected the kitchen and found it well-stocked, and organised. It had attained a five star food hygiene rating, which equates to 'very good'. There was a white board on the wall in the kitchen which detailed who was on a textured diet and who had a requirement for a gluten free diet. It did not record every person who was diabetic nor who required a fortified diet. There were four people on food supplements, but the kitchen staff had not been made aware of this and therefore were not fortifying these people's diets. However, the dietician was present on the second day of inspection and was intending to work with all staff to ensure people were provided with a well-balanced meal in accordance with their wellbeing requirements.

We saw evidence in people's care records that they had access to other healthcare professionals including G.P, dietician, speech and language therapy, occupational therapy, and chiropodist.

Alwoodleigh is a converted Victorian property with a double storey extension. Bedrooms for people with residential care needs were on the ground floor and nursing care was provided on the second floor accessed by a staircase and a lift. All bedrooms had ensuite toilet facilities and some bedrooms contained ensuite level access showers. There was an adapted bath on each floor and a level access shower on the first floor. This was broken at the time of our inspection and was waiting to be replaced. There was a well-equipped laundry in the basement.

Good

Is the service caring?

Our findings

We asked people using the service whether staff were kind and caring. One person told us, "They look after me very well here". Another said, "The staff here are fantastic". Other comments we received included, "I'm very happy here, the staff are great we are all one big family here, they are very caring, I've no complaints. We had a lovely Christmas with the staff" and "The staff here will do anything you need them to do but I do what I can for myself". One relative we spoke with about the care provided told us, "First class from the manager downwards." A visiting relative when asked about the caring attitude of the staff told us, "80% of the staff are great." Another said, "There are good and bad. Some of the staff are passionate about caring."

Staff told us the care they provided was good and the care interactions observed were kind and caring. In the lounge area of the nursing unit we observed one staff member speaking kindly and patiently to a person who was distressed. They dealt with the person in a gentle and sensitive manner which calmed them down.

Staff told us they respected people's dignity and privacy by closing doors when undertaking care, closing curtains and covering people when assisting people with personal care. We observed people who required attention to their hygiene following eating were attended to by carers who showed respect and dignity in a timely manner. Staff had received training in how to ensure privacy and dignity was respected and we saw this had been discussed at the team meeting in December 2016.

Staff told us how they encouraged people to remain independent whilst at the service and those people who could get themselves washed and dressed were encouraged to do so, or do the parts they could manage without support. People's abilities were recorded in their care plans to guide staff to support independence.

We saw evidence the service used advocates when appropriate to support people who required assistance to ensure their rights were protected. Access to advocacy ensures that vulnerable people are able to have their voice heard on issues that are important to them, defend and safeguard their rights and have their views and wishes genuinely considered when decisions are being made about their lives.

At our previous inspection the nursing unit had difficulty maintaining confidentiality as this floor had no separate nurse's office. Staff used a desk and filing cabinet for care plans on the landing which meant they had difficulties ensuring their conversations with relatives and other staff remained private. We found at this inspection the spare bathroom had been converted to a nurse's office which provided privacy and a more professional area for nurses to update care records, although the desk was extremely small and not ideal.

We spoke with one of the nursing staff, who told us they completed end of life care plans for those identified as requiring this stage of care. They said they ensured people were comfortable and pain free at this stage and anticipatory medicines were available when required.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they were happy with activities on offer. One person told us, I like joining in with the activities but you don't have to if you don't want to". Another said, "It's just like living at home, everyone is so friendly, there is always something going off, nobody bothers you if you don't want to join in". A further person told us, "I'm not sociable, I don't go out of my room but I could if I wanted. I like my own company, I'm quite anti-social. I like to read, listen to the radio, do the crossword, and watch TV. The staff are always coming in to see if I need anything. It was my birthday last Sunday and the staff came in with a birthday cake for me singing Happy Birthday, that was nice." One relative we spoke with told us their relation could not attend the film viewing but the activities coordinator had come to their room with popcorn to make them feel part of the event.

The home employed an activities coordinator who was on leave on the first day of our inspection and a member of care staff was undertaking activities on this day, and we observed people enjoying the group activity taking place in one of the communal rooms in the residential unit. The activities coordinator was present during our second day of inspection and demonstrated their enthusiasm for their role in adding meaning to people's daily lives. They showed us how they recorded the activities each person undertook and how they evaluated each session Activities on offer ranged from painting, crafts, quizzes, games, dice games, bingo, bowling, and a film show.

At our previous inspection, we found that people who had been admitted recently had either partial or no care plans in place and inadequate assessments in relation to their care and support needs. At this inspection we found there had been some improvements in care planning. Preadmission assessments had been completed in detail to ensure the home could meet the needs of the people coming to live at Alwoodleigh. We found some people's life histories had been completed in detail, to tailor care to meet the person's needs based on past life experiences, preferences and previous choices. Not all the care plans had been transferred over to the registered provider's new paperwork and some files contained a mixture of both old and new paperwork which made some of the care files difficult to read due to the amount of information in the files, which was not always current. The regional manager advised us they were prioritising ensuring all care files were transferred to the new system of recording to ensure records were consistent.

Care plans were recorded in a person centred way and mostly reflected an accurate record of their care needs and how they wanted to be cared for. Care files were regularly reviewed and evaluated to ensure care provided was meeting people's needs although they lacked evidence people had been involved in these evaluations. Staff knew people well and how to care for them which compensated for some of the shortfalls in records.

There was a daily monitoring sheet which staff initialled when any care had been provided but there was only space for this to be completed once a day, so if staff did not write this into the daily records there was no evidence support had been provided in areas such as oral health more than once each day. Some daily records evidenced people had daily choices such as people had been offered a bath but others just

evidenced the tasks that had been carried out. The manager told us they were focussing on training around recording practices to ensure this was carried out to a high standard.

The manager told us they tried to ensure people's bedrooms were personalised and spoke with families to ask if they can bring personal effects to the home. They said the handyman was available to help put up pictures on the walls. We found bedrooms were personalised to people's preferences and people were able to change bedrooms if alternate rooms were available.

At our last inspection, we found there had been a culture of not recognising concerns which could have a positive effect on the service in terms of identifying patterns and themes to enable the service to improve. At this inspection we could see that when complaints had been formally recorded we could see they were acted upon and resolved to the complainant's satisfaction. Relatives we spoke with during our inspection told us they had no hesitation discussing any concerns with the manager who they told us always acted on their concerns and issues were always resolved. However, not all concerns were recorded. Prior to our inspection, we were contacted by a relative of a person who used to live at the home, who had raised concerns but these were not recorded although the manager could give us verbally the information in relation to these concerns. By not recording these concerns, and how the service responded, was a missed opportunity to demonstrate how effective they were at resolving issues and improving their service.

Requires Improvement

Is the service well-led?

Our findings

There had been a manager in post since July 2016, who was in the process of registering with the Care Quality Commission. They were supported by a regional manager who visited the home at least once every fortnight but was in daily telephone contact. They told us their biggest challenge since taking over was recruiting nursing staff. The clinical nurse lead had left the home and they were actively recruiting to that post. Two nurses from the registered provider's other home was supporting the service with nursing standards. They had recruited nine staff since starting at the service ranging from laundry staff, care staff, a housekeeper and activities coordinator. This meant there had been a period of change for people at the service and staff. The manager shared their vision with us "To move the home forwards with a good staff team." They said, "It's a lovely home. We are moving up the hill. We are not at the top."

Staff told us they enjoyed working at the home and staff morale had increased. They told us the manager was always available and they could ring them at home if they were not at the service. They told us the manager was open to suggestions although the staff we spoke with hadn't yet made any suggestions to improve the service delivery.

At our previous inspection we found there had been a lack of leadership at the home. At that time the home had recently had a new management company take over from their previous company which had caused difficulty with records and paperwork. However, the new management company had been in post for a period of 12 months by this inspection. They were still in the process of implementing new forms and procedures. One new process the regional manager advised us was to be implemented immediately was a manager's daily report which the manager will be required to complete each day on staffing levels, handover, infection control, care practice observation, medication and nutrition and a discussion with visitors and people using the service. If completed fully, this would give the regional manager an up to date record of how the service is running.

We reviewed a number of audits which took place at the home. This included maintenance audits, catering department audit and housekeeping audits. We examined the facilities certificates such as insurance, gas and electric; lift servicing and water testing were all in order. There had been gaps in some of the maintenance audits as the home had a period without a handyperson and it was not clear when maintenance actions had always been completed as there were not always dates next to actions. The manager told us they had recently employed a new handyperson for 40 hours each week to deal with maintenance issues. We also reviewed the weight loss audit which detailed actions to combat weight loss such as increasing the number of snacks a person might be offered. Although, as referred to previously, the kitchen staff had not been alerted to which people would benefit from a fortified diet.

We found the system for auditing care plans and daily records was not adequately robust as this had not picked up the issues we found with care records such as the lack of best interest decisions were people lacked capacity, the lack of detail in the moving and handling risk assessment and care plans, and the lack of assessment of risk around the use of equipment (with the exception of bed rails, where assessments were in place.)

The registered provider undertook a quality audit every six months. We were given the report following the audit completed in September 2016. Many areas had improved but we found issues that had been highlighted in this audit had not been actioned by the time of our inspection as we found identical issues to the auditor such as issues with covert medicines, mental capacity assessments, care plans and the kitchen staff not having a record of who required a fortified diet. There was no action plan aligned to the report so that issues could be reported as completed.

The regional manager undertook a monthly quality monitoring report from their visit during the month. This report contained an analysis of the review of information from the homes such as audits, and also their observations of practice during their visits. They were aware of areas which needed to improve at the home, and were working with the manager to ensure improvements were made and sustained.

We found staff meetings had been held and recorded every month and staff signed to say they had attended. We reviewed the staff meeting minutes for December 2016 and January 2017 which confirmed these were a forum to cascade information to staff although there were no actions at the end of the minutes which could be reviewed at the next meeting to ensure outcomes were achieved between meetings. They did not evidence the views of the staff had been sought so they could influence improvements at the home. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service.

We reviewed the minutes of the relatives and residents' meeting which had taken place 8 and 12 December 2016 respectively. There was no action plan arising from the minutes to confirm who was responsible for the actions which could be reviewed at the next meeting to confirm the home had listened to and acted on the views of people using the service and their relatives. The minutes recorded relatives had recognised improvements had been made at the home.

The registered provider had sought the views of people using the service, relatives and staff in September 2016 by means of a questionnaire. They received a response from eight people using the service and 13 members of staff. This contained a section on "This is what you said" and "This is our response" in relation to any comments made, although the only comments were from staff.

The service was meeting its registration requirements in terms of statutory notifications sent to CQC. They had displayed the ratings from the previous inspection as required in a prominent place in the reception area.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of recorded evidence in relation to risk assessment of equipment and method in moving and handling care plans. One person's medicines had been given in crushed from without the necessary checks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Decisions made on behalf of people who lacked capacity were not recorded in line with the requirements on the MCA 2005 and the associated Codes of Practice. The provider had failed to identify, and assess the risks to the health, safety and welfare of people who use the service to enable them to reduce the impact of the risk on the people using the service.