Elmwood Residential Homes Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

The inspection took place on 21 and 28 April 2015 and was unannounced. We last inspected the service on 26 August 2014 and we did not identify any concerns. This inspection was brought forward in response to anonymous concerns raised with us.

The service is registered to provide accommodation with personal care for up to 38 people. The home is mainly for people over 65 years of age, who may have physical disabilities due to older age. The home was fully occupied when we visited, one person was staying temporarily for respite care.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People were offered day to day choices and staff sought people's consent for care and treatment. However, where people lacked capacity, staff did not demonstrate a good understanding of their responsibilities under the Mental Capacity Act (MCA) 2005 or about the Deprivation of Liberty Safeguards (DoLs). Several MCA assessments needed reviewing and updating as they did not reflect the person's current level of capacity. There was no record about how relatives and other professionals were consulted and involved in decision making in people's 'best interest'.

People were supported to receive ongoing health care support. However, some people's health care needs were not being appropriately managed. This was because staff did not demonstrate a good understanding of how to use some evidence based tools used for assessing people's health care needs or formulate a detailed care plan in response. For example, two people's weight loss was not being promptly or fully responded to and they remained at risk of malnutrition.

Although staff were knowledgeable about people's needs, they were at increased risk because staff did not have access to detailed care plans about each person's care and treatment needs. Care records were not regularly evaluated and updated as people's needs changed. This meant they could not be relied upon as an up to date and accurate record about each person.

People, relatives and health and social care professionals were overwhelmingly positive about their experiences of the home. They spoke about how friendly and welcoming staff were, the homely atmosphere and well organised and managed the home was. A few relatives expressed some concerns about the experiences of people who were less able and lacked capacity.

People and relatives said staff working at the service were caring, compassionate and treated them with dignity and respect.

People were supported to remained active, and be as independent as possible. People had access to regular exercise classes, physiotherapy and were supported to access mobility equipment to remain active. Most people led full and varied lives. They were supported to maintain their interests and hobbies and to access the community regularly.

The culture of the home was open and friendly. People, relatives and staff regularly popped into the registered manager's office to chat, ask questions and raise any concerns. Systems were in place to monitor the quality of care and improvements were made in response to feedback received.

We identified three breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected because staff understood signs of abuse and were confident any concerns reported were investigated and dealt with.

Medicines were given safely and as prescribed.

People were supported by enough staff so they could receive care and support them at a time convenient for them.

Accidents and incidents were reported and action taken to reduce risks of recurrence. The premises and equipment were managed to help reduce risks.

Is the service effective?

Requires Improvement

Some areas of the service were not effective.

Staff did not demonstrate a good understanding of their responsibilities in relation to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Improvements were needed in keeping MCA assessments up to date and in 'best interest' decision making.

Some people's health care needs were not being appropriately managed. Staff did not demonstrate a good understanding of how to use evidence based tools for assessing people's health care needs. Detailed care and treatment plans were not in place in response to needs identified.

Staff received regular training and had opportunities to undertake further qualifications in care.

Is the service caring?

Good

The service was caring.

People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Staff were kind and compassionate towards people and had formed positive caring relationships with them.

People and their representatives were supported to express their views and in decision making.

Is the service responsive?

Requires Improvement

Some areas of the service were not responsive.

People were at increased risk because there were no detailed care plans to inform staff about their care and treatment needs.

Summary of findings

Staff knew people well, understood their needs well and cared for them as individuals.

People felt confident to raise concerns. Complaints were listened to, investigated, and were appropriately responded to.

Is the service well-led?

Good

The service was well-led. The service had a registered manager and the culture was open, friendly and welcoming.

People, relatives and staff expressed confidence in the management and said the home was organised and well run.

People and relatives' views were sought and taken into account in how the service was run.

The provider had a variety of systems in place to monitor the quality of care provided and made changes and improvements in response to findings.

Elmwood Residential Home Limited

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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 and 28 April 2015 and was unannounced. The inspection team comprised of one inspector. Before the inspection we looked at information we had received about the home such as notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 16 people using the service, seven relatives and friends and we looked in detail at five people's care records. We spoke with 12 staff, looked at five staff records, at training and at quality monitoring records. We sought feedback from health and social care professionals who regularly visited the home including GP's, community nurses, other therapists and commissioners and received a response from seven of them.

Good

Is the service safe?

Our findings

People and relatives said they felt safe and secure at the home. One person said, “The best thing about the home is feeling safe and secure with help at hand”. A relative said, “I have never seen anything untoward here”.

Staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. All staff said they could report any concerns to the registered manager or deputy manager and were confident they were dealt with. The provider had safeguarding and whistle blowing and policies available so staff were clear how to report concerns. Staff were asked if they had any concerns during staff supervision. A concern had recently been reported by a member of staff, which was fully investigated and dealt with. This showed people were protected because concerns about suspected abuse were taken seriously and followed up.

Two new care staff had been employed in the past six months. All appropriate recruitment checks were completed for one applicant to ensure fit and proper staff were employed. These included police and disclosure and barring checks (DBS), checks of qualifications and identity and obtaining references. For one applicant, not all checks were undertaken to seek evidence of satisfactory conduct in previous employment or verify why that employment ended. Since the inspection, the provider confirmed they had taken action to address this.

Medicines were managed in a way that ensured people received them safely and as prescribed. We accompanied the deputy manager administering the medicines at lunchtime. Each person was given their medicines in a safe way. Medicines were stored in line with current regulations and guidance. Medicines which required refrigeration were stored appropriately and fridge temperatures were monitored to ensure they were kept at recommended temperatures. There were systems in place for recorded all medicines received and unused stocks were returned to pharmacy for destruction.

People's medicines were administered via individual dosset packs dispensed by the pharmacy. Some people had extra tablets stored in separate packets. We found the tablet count for one drug showed two tablets were missing compared with the number recorded as given. When we tried to check these, we found the Medicine Administration Record (MAR) did not document the number of tablets each time a new MAR sheet was started. This meant it was not possible to know how many tablets there should be. We discussed these findings with the registered manager and the deputy manager and asked them to undertake an audit. When we returned on the second day, the missing tablets were located and accounted for. The home had also implemented improvements, so that the remaining number of tablets were recorded on each time a new MAR chart was commenced. This meant all tablets could be checked and accounted for.

Accidents and incidents were reported and reviewed by the manager or deputy manager to identify ways to reduce risks for each person as much as possible. Where a person had several falls, a falls risk assessment was completed which identified a range of further measures to try and reduce the risk. For example, making sure the things the person needed were at hand and encouraging them to ring staff for help when they mobilised. One person was referred to the community 'falls' team for assessment to identify further strategies to prevent their risk of falls. A second person had just returned from hospital and staff were encouraging them to use a special harness to help them keep safe when using their wheelchair.

People who needed help to mobilise, such as by using a hoist, said they felt safe and staff were trained and used equipment appropriately when moving them. The home was adapted to meet people’s mobility needs; it had wide corridors, a lift to the upper floor, a high/ low bath had been installed and people confirmed the garden was accessible. Individual fire risks assessment were in place and each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of a fire. Environmental risks assessments were also completed and showed measures taken to reduce risks as much as possible.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. Staff worked in an unhurried way and were available to support people at a time and pace convenient for them. Staff on duty were mostly long term employees who knew people well, were experienced in providing care, many of whom had qualifications in care.

The registered manager had devised a tool to assess staffing levels at the home which they adjusted according to people’s needs and activities planned. For example, all

Good

Is the service safe?

staff started at seven when the home was busy and there was an extra member of staff on duty each evening until nine to help people get ready for bed. The registered manager was currently recruiting extra staff to work at weekends and used agency staff to cover any gaps meanwhile. Staffing rotas showed recommended staffing levels were maintained.

Requires Improvement

Is the service effective?

Our findings

Staff demonstrated a limited understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and did not always act in accordance with them. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

When people first came to live at the home, their capacity was assessed in accordance with the Mental Capacity Act (MCA) 2005. Two people's records we looked at were not accurate or up to date about their current level of capacity. Staff confirmed these people had memory problems, and were confused at times. The registered manager described them as having fluctuating capacity which other entries in their records confirmed this. For example, one entry said, "(Person) is confused about where she is and when she is going home".

We asked three relatives and a friend of people who lacked capacity about how staff at the home consulted and involved them in decision making about the person. Their responses varied, one said they were regularly consulted, another said they were kept informed rather than consulted about the person. A third said staff didn't really communicate much with them about the person and a fourth said staff sometimes consulted with them about decisions, but not always.

One relative was particularly concerned the person may be isolated as they remained in their room all the time. This person was unable to move without staff support. Staff confirmed they rarely took the person downstairs nowadays. They said it was stressful for the person and confirmed they had explained this to the family. However, there was no record of who was consulted or involved about the decision that this person should remain in their room in their 'best interest'.

We noticed a strong odour of stale urine in another person's room, something which was not present anywhere else in the home. Staff told us the person often refused personal care and were frequently incontinent of urine. They described how they tried to get the person to accept help with personal care but said they weren't always successful. Their care records showed the person refused personal care several times in the past week. This meant they were at increased risk of getting sore skin and the odour was not very dignified for them. The registered manager said the person had fluctuating capacity. However, professionals and the person's relative had not been consulted or involved in any 'best interest' decision about further steps needed in relation to their personal care.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed staff sought consent for day to day care and treatment decisions. However, for people who lacked capacity or had fluctuating capacity, there was no written information about how those people could be supported to make decisions. However, staff we asked about this, could describe how they helped those people to make day to day decisions. For example, a staff member described how they offered a person two outfits each morning so they could choose between them.

Staff said most people were free to come and go but some people chose not to go out unless they were accompanied by staff or relatives. The front door was not locked; although one staff said they occasionally used the bolt to lock the front door, if a particular person wandered towards that door. An external door near another person's room was locked, as was the garden gate. Staff confirmed these safety measures were for security of people who lived at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager said the home had not made any applications to deprive people of their liberty. We asked the registered manager to consider whether they needed to submit applications to the local authority deprivation of liberty team for three people at the home. This was because of the Supreme Court judgement on 19 March 2014, which widened and clarified the definition of deprivation of liberty. Since the inspection, the registered manager has confirmed they were seeking the advice of the local authority deprivation of liberty team about these three people.

Requires Improvement

Is the service effective?

People said they felt supported by staff that were able to meet their needs. However, we found some people's health care needs were not effectively managed. This was staff did not demonstrate a good knowledge of how to use some evidence based tools for assessing people's health care needs. For example, the Malnutrition Universal Screening Tool (MUST), an evidenced based tool to identify people at risk of malnutrition. There was a lack of detailed care and treatment plans for people in response to health needs identified. In relation to nutritional risks identified, staff were not documenting actions taken to reduce risks, such as recording nutritional intake or evaluating actions taken. We identified ongoing concerns about malnutrition for two people in relation to unexplained weight loss, which were not being appropriately responded to.

For example, one person's care record showed they had lost weight each month for over two years. In March 2015, the person's MUST screening tool showed they were at moderate risk of malnutrition. There was no detailed care plan in place about how to manage this risk. The nutritional tool identified further steps staff needed to take to reduce risks for this person, such as documenting the person's food intake for a three days period and trying to increase it. The person's GP had been asked to see them in March 2015 and prescribed nutritional supplements for them. Staff said the person didn't like these and weren't taking them. Staff told us this person had a good appetite, although one staff member said they didn't eat as much as they used to. Senior staff said the persons' GP wasn't concerned as this pattern of weight loss was similar to another family member. Since the GP's visit, the person had lost more weight in April 2015 but no further action was taken, although the nutritional risk assessment tool indicated referral to a dietician was recommended. However, the reasons for not taking further actions were not documented in the person's care records. We looked at the person's daily records for the previous week but they did not include any information about what the person had eaten.

Our findings meant we could not be assured from the information available whether all appropriate steps had been taken to manage two people's weight loss. We discussed our concerns with the deputy manager and registered manager and asked them to seek further advice in managing these people's nutritional risks, which they confirmed they have done.

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

Most people were very pleased with the food provided at Elmwood. One said, "You couldn't wish for better food". There was a choice of menu for each meal. Menus were planned four weekly in advance and reviewed periodically in consultation with people. The chef told us the provider supported a local food health charity set up to provide information about tasty and nutritious food. They used several of their recommended recipes for meals on the menu. All meals were cooked from fresh and included plenty of fruit and vegetables. The chef described how they enriched foods with cream and butter to make them more nutritious. Catering staff had additional information about people's likes and dislikes, and said there had no current concerns about anyone's nutritional intake. At mealtimes, anyone who needed help to eat and drink or to cut up their food was appropriately supported. Hot and cold drinks were offered to people regularly throughout the day.

People had a access to healthcare services for ongoing healthcare support. This included regular visits by local GPs, by community nurses, a physiotherapist and two chiropodists. Health professionals said staff contacted them appropriately and generally followed any advice given. One healthcare professional said, "One of the nicest places I visit, a good atmosphere, plenty of staff, very helpful and friendly".

Staff training records showed staff received regular training and updating. This included training on safeguarding adults, health and safety, infection control, moving and handling. The deputy manager was trained to provide staff moving and handing training for staff. One staff member who accompanied people on outings in the minibus and helped people on and off the bus said they had not received any moving and handling training. Most care workers we spoke with had qualifications in care and or other relevant qualifications so were appropriately qualified. Most training was DVD's and completion of assessment questionnaires. A staff member said they would prefer some more taught courses as they didn't find DVD's all that helpful.

We spoke with two recently appointed staff about their knowledge and skills opportunities they received when starting work at the home. One staff member confirmed they had completed an induction programme, and another member of staff was still undergoing induction. They told

Requires Improvement

Is the service effective?

us about their initial induction course and how they worked alongside experienced care workers to get to know people before working alone. Staff received regular one to one supervision, where they had an opportunity to discuss their practice and identify any further training and support needs.

Good

Is the service caring?

Our findings

People and relatives gave us overwhelmingly positive feedback about the care provided at the home. When we asked people what they liked best about the home, one person said, “Everybody is very kind”, another said “It’s absolutely marvellous, if you can get in here, you are very lucky” and a third person said, “I’m perfectly happy”. People described staff as “Helpful, sympathetic, patient, and friendly”. A relative said “People get looked after here”. A health professional said they were particularly impressed with how compassionate and supportive staff at the home had been to a person when their friend died.

One person, commenting on people sitting in the lounge said, “My observation is that vulnerable people are well looked after here, there is always someone around and no one is left to call out”.

People and relatives described the variety of ways staff supported them which they had appreciated. One person was in the process of moving to a room more suited to their needs. They said the deputy manager was helping them to arrange their furniture and sort their things, which they were very pleased about. Another person said, “They do all sorts of little things” and went on to describe how a staff member had organised replacement batteries for their hearing aid. A relative said how they had appreciated a member of staff accompanying them to buy a new dress for the person's 90th birthday celebration.

Staff were relaxed and friendly, they knew about people’s individual preferences and how they liked to spend their day. They worked flexibly in response to people’s individual needs and wishes. Staff knew about people’s disabilities and how best to communicate and support the person. For example, how one person was deaf and responded better if you spoke to them into their left ear.

People’s cultural and religious preferences were known and people were supported to attend church and other community events, such as local coffee mornings.

Staff were caring and compassionate. At lunchtime, a person was feeling unwell. Staff noticed immediately and took immediate action to help the person back to their room and arranged for them to have pain relief and offered them a snack. On another occasion, we accompanied a staff member to visit a person’s room. When the person realised which staff member was in their room, the person smiled and was very pleased to see them.

People said staff treated them with dignity and respect at all times and made sure their privacy was respected when supporting them with personal care. They confirmed staff offered them choices and respected their decisions. Relatives and friends said staff welcomed them whenever they visited. People who preferred to spend most of their time in their room said their choice was respected.

People confirmed their views were listened to and actions were taken in response. For example, about the importance of staff wearing their name badges. This was in response to people’s feedback about some staff not wearing them.

Requires Improvement

Is the service responsive?

Our findings

People were at increased risk because there were no detailed care plans about their care and treatment needs. Although people's needs were assessed, the outcome of the assessments did not result in developing a detailed care plan in response to each individual need identified. This meant relevant information staff needed was not easily available to staff them to reduce people's risks to a minimum. The lack of detailed care plans meant staff were not prompted to evaluate, review and update care records as people's needs changed. This increased risks further for people whenever staff caring for people did not know their needs well, such as agency staff.

For example, several people were identified as being at increased risk of developing pressure ulcers. However, following assessment, there were no written care plan in place for people about how to manage and reduce this risk. Instead staff were referred to the persons moving and handling plan, which had some, but not all of the relevant information needed. For example, it included any pressure relieving and moving and handling equipment needed such as a hoist. However, other information was missing such as any specific skin care needed, how often the person should be supported to change their position, the settings needed for pressure relieving equipment, and night time care instructions.

Community nurses told us about one person who was sitting for long periods and whose skin had become red. We followed this up to see what action had been taken in response. The deputy manager said this person was being encouraged to stand up for a period at regular intervals each day, in accordance with the community nurse's instructions, which the person confirmed, although there was no care plan in place about this. Staff were knowledgeable about people's individual pressure area care, and said they would report any concerns about skin redness to senior staff. We saw lots of pressure relieving equipment in use around the home. Staff demonstrated they understood the importance of repositioning people regularly, although often this information was not documented.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records were not individualised and did not capture details people's personal history, individual preferences, interests and aspirations.

People said they were involved in making decisions and planning their own care, particularly when they first came to live at the home. They had been asked about their needs, likes and dislikes and how they would like to receive their care, treatment and support. However, people and relatives reported they were not involved in regular reviews and updating of their care records. Other aspects of people's care was not well documented in their records. For example, one person had a food and fluid chart. However, the entries lacked detail about how much the person was eating and drinking each day.

The registered manager and deputy manager said daily records and daily handover meetings provided staff with key information about people's care needs and any changes. However, daily records we looked at did not provide details about one person's eating and drinking, or confirm how often a second person, at risk of developing pressure sores, was supported to change their position.

Two people's relatives expressed some concerns about whether the person was isolated and said they did not know how often staff spent time with them. One said, "When I visit her, I see they are always lots of staff, but I don't think they do an awful lot for her". Another said, "The home seems lovely for people who are up and about and can do their own thing but I go at all different times of day and I don't see anyone talk to her". We followed these concerns up with staff who described how they checked on those people regularly throughout the day about every two hours. However, these staff checks on people's welfare and to spend time with them to prevent isolation were not consistently documented, so the frequency of checks could not be verified.

People described the home as friendly and welcoming and said there was lots to do. Some people spoke about friendships they had developed or renewed with other people at the home which were important to them. One person said, I'm very happy with the care here, there is always lots going on". A relative said, "I never feel my mum is lonely here, there is always lots going on."

There were several lounge areas where people could get together and some quieter spaces for people who preferred those. Several people enjoyed reading their daily paper,

Requires Improvement

Is the service responsive?

and lots of people joined in a weekly knowledge quiz. In the afternoon, several people enjoyed listening to opera. There was an activity programme each week which included coffee mornings as well as musical entertainment, films and a visits from a variety of entertainers. The home had a fish tank and two budgies, which people enjoyed. There was a garden which included a pond and a vegetable patch and a wide variety of flowers, shrubs and trees. Planting troughs with wheelchair access had just been purchased so people with could get involved in planting and growing. A minibus with wheelchair access was available so that people were supported to go on lots of trips out to local attractions. A hairdresser visited the home each week and a mobile library service visited monthly. People said they enjoyed the variety of activities and trips available at the home.

People said call bells were answered promptly during the day and at night. Staff made sure that people had everything they needed before they left them. For example, several people we met had their newspaper, book, a drink, glasses, and call bell near them.

People were supported to mobilise and retain their independence as much as possible. For example, staff arranged for a person to visit Exeter mobility centre for an assessment and were awaiting the equipment recommended to help the person mobilise. Several other people at the home also had mobility aids so they could move independently. A physiotherapist visited the home twice weekly to helped people to remain as active as possible. An exercise class was provided each week to encourage people to remain active.

People and relatives were encouraged to give feedback at residents/relatives monthly meetings and minutes showed what actions were taken in response. Minutes showed people's suggestion about having planting troughs for the patio were acted on and one person made a detailed list of suggested plants. People discussed and chose the names of two budgies recently purchased. Some people said their drinks weren't very hot, and staff were reminded to check this. Other issues raised included minor repairs and maintenance issues. Minutes showed monthly meetings were well attended, that people's views were listened to and action taken in response was documented.

People were encouraged to raise any concerns or complaints with the registered manager or deputy manager who were easily accessible each day in the home. People confirmed any concerns were investigated and responded to quickly. A complaint log was kept, which detailed actions taken in response. Staff supervision records showed that issues raised by people were discussed with staff so that lessons could be learned from people's experiences.

The home had a complaints policy in each person's room, which included details about how people could raise concerns outside of the home, if they were dissatisfied with how the home had responded to their concerns.

Good

Is the service well-led?

Our findings

The registered manager operated an open door policy to people, relatives and staff. Their office was situated in the middle of the home and people, relatives and staff popped in regularly to ask questions, pass on information and seek advice. This meant any concerns were dealt with before they became complaints. The service had a long standing registered manager and two deputy managers. All three senior staff worked in practice within the home. This meant they provided support, advice to staff and day to day monitoring of the quality of care provided to people.

People, relatives, staff and visiting professionals all said the home was well organised and managed. One person said, "The manager is visible, everything is under control". A relative said they were particularly impressed when they knocked on the door to arrange an appointment to look at the home and the deputy manager invited them in immediately. They said, "They were very open, they had nothing to hide, that spoke volumes to me". A care professional said, "One of my favourite homes, it's clean, the relationship between staff and people is very good" and another said, "An excellent standard of care, I'd be more than happy for my relative to live there".

One staff member said there was a "homely atmosphere" and that people and staff were treated like an extended family. Another staff said, "Staff stay for a long time, that's a good sign. I'm so happy there". Although there were no staff meetings, staff said communication was good, staff were well supported, and daily handover was effective in keeping them up to date about each person who lived in the home. Staff also said there was time during handover to discuss issues and get update information about the home.

The provider visited regularly and spoke with people and staff to get their feedback. Verbal and written feedback from people and relatives was mostly very positive about the home. Following recent concerns raised anonymously about the home, the provider arranged to interview people in private to check if they had any concerns. The report sent to the Care Quality Commission showed people were very satisfied with the service. This meant there was no evidence to substantiate the concerns raised, which we confirmed during the inspection.

Essential messages between staff were captured in a communication book that all staff were aware of. There was a system in place to monitor and ensure staff received regular supervision and update training.

Accident/ Incident reports and complaints received were monitored to identify any trends and identify people at increased risk and showed that actions were taken to reduce risks. Where concerns were identified about staff performance, these were managed appropriately in accordance with the provider's policies and procedures. Individual staff supervision was used to re-enforce the values and behaviours expected of staff. It was also used to discuss people's feedback and any lessons learned from accidents/incidents or other concerns.

There was a range of quality monitoring systems in place. These included cleaning schedules and records kept of daily, weekly and monthly cleaning. There were documented systems for cleaning and checking of equipment such as hoists, hoist slings and wheelchairs. A deputy manager had a lead role for managing and monitoring medicines at the home. Weekly fire checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken.

All electrical, gas and emergency lighting and fire equipment was serviced and tested regularly. Servicing contracts and evidence of recent servicing was seen for the passenger lift, lifting equipment, the call bell system and for vehicles. A maintenance person worked four days a week at the home and there was a system in place for staff to report repairs and maintenance needed, which was signed when the work was completed. The registered manager outlined further environmental improvements planned to replace flooring downstairs.

The home had robust systems in place helped to protect people from financial abuse. People were discouraged from having too much money in their room, and arrangements were made for monies to be kept securely for people, with receipts and clear audits.

The registered manager was very aware of recent regulatory changes and was currently completing a course about these. The registered manager notified the Care Quality Commission about important events they were required to tell us about. Where areas for improvement were identified and discussed during the inspection, the

Good

Is the service well-led?

registered manager was open to feedback. They confirmed their commitment to make improvements required. Since the inspection, they have e mailed us about actions already underway in relation to these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Where people lacked capacity, and were unable to give consent, staff did not always act in accordance with the Mental Capacity Act 2005. Some people's mental capacity assessments were not up to date and there was no record of 'best interest' decisions made. Professionals and relatives were not always consulted and involved in making decisions in people's best interest. This is a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Some people's health care needs were not being appropriately managed. Staff did not demonstrate a good understanding of how to use some evidence based tools used for assessing health care needs. They did not formulate a detailed care plan in response to needs identified. This is a breach of regulation 12 (1)(2)(a), (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

People were at increased risk because there were no detailed care plans to inform staff about their care and treatment needs. People's individual needs and care plans were not regularly evaluated and updated about changes.

This is a breach of regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.