Shaftesbury Care GRP Limited

Hamilton 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 carried out an unannounced comprehensive inspection on this home on 22 and 26 January 2015. Three breaches with the legal requirements of the 2010 Regulations which corresponded to the 2014 Regulations were found. The administration of medicine practices in the home were not safe as the protocols for take as necessary (PRN) medicines did not include sufficient detail. Staff received formal supervision, but this was not planned and was delivered on an ad hoc basis. Care plans did not consistently or sufficiently detail people's needs to ensure their welfare and safety at all times. At the last inspection on 22 and 26 January 2015 we asked the provider to take action to make improvements and the service had addressed these actions.

We undertook this unannounced comprehensive inspection on 15 August 2016 to check that they had followed their plan and to confirm that they now met legal requirements. At the inspection on 15 August 2016 we found the provider had taken some steps to address these concerns and had introduced clear protocol documents to be implemented and completed by staff for the administration of PRN medicines. However we found this practice was not embedded in the service. Whilst information contained within care plans remained inconsistent people were receiving the most up to date care. Improvements had been made with the monitoring and completion of staff supervision and appraisals.

Hamilton House is a nursing home which provides accommodation, personal and nursing care to 60 older people, some of whom live with dementia. The home has three floors, with a lift which gives access to all floors. At the time of the inspection 59 people lived at the home.

There was a registered manager in place at the home. 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.

People felt safe and staff knew how to keep people safe. Medicines administration was safe however there were still concerns with the lack of information regarding (as required) PRN protocols. Risk assessments were in place and staff were aware of the risks to people and themselves. There were sufficient staffing levels and safe recruitment practices had been carried out.

Staff felt well supported and received regular supervision and appraisal. Training plans were in place and staff received regular training however staff did not always feel the training gave them the skill or confidence to support people living with advanced stages of dementia and behaviours that were deemed to be challenging. Staff showed a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS were in place appropriately for people.

People's nutritional needs were being met however people may not always be encouraged to eat independently. People were given a choice of meals; however people with dementia were unable to recall

the choice of meal they had made from the previous day.

People were supported to access healthcare services.

Staff were kind, caring and respected people's privacy, dignity and independence when providing them personal care. There were good interactions with the majority of people.

Where possible people made their own decisions about their care and were supported to do so if they were unable to make these decisions.

Care plans were in place and an assessment of need was completed for people when they were admitted to the home. People's needs were met but care plan information was inconsistent and people's turning charts were not always completed accurately. Care plans were personalised and included people's preferences.

Activities took place but we could not be sure they were always meaningful to people. People who remained in their rooms or who were nursed in bed did not have any interaction with staff other than with personal care. We have made a recommendation about implementing appropriate guidance on activities which were meaningful and supportive to meet people's needs

Complaints processes were in place and people knew how to complain and felt confident to do so.

Audits were in place to assess the quality and safety of the home, however care plan audits were not documented and as a result care records were inconsistent and did not give an up to date reflection of people's most current needs.

Staff worked to the values of the home but were not always aware of what these values were. Staff felt supported and were confident in raising concerns to the manager.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told 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 always safe.

Medicines administration was safe however there were still concerns with the lack of information regarding (as required medicines) PRN protocols

People felt safe and staff knew how to keep people safe. There were enough staff and recruitment practices were safe.

Risk assessments were in place and staff were aware of the risks to people and themselves.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had regular supervision and appraisal and training plans were in place. Staff did not always feel the training gave them the skill or confidence to support people living with advance dementia and behaviours that were deemed to be challenging.

Staff showed a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were being met however people may not always be encouraged to eat independently. People were given a choice of meals however people with dementia were unable to recall the choice of meal they had made from the previous day.

People were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and respected people's privacy, dignity and independence when providing them personal care.

Where possible people made their own decisions about their care and were supported to do so if they were unable to make these decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were in place, personalised and reflected people's preferences. People's needs were met but care plan information was inconsistent and people's turning charts were not always completed accurately.

Activities took place but we could not be sure they were always meaningful to people. People who remained in their rooms or who were nursed in bed did not have any interaction with staff apart from personal care. We have made a recommendation about activities.

Complaints processes were in place and people knew how to complain and felt confident to do so.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits were in place to assess the quality and safety of the home, however care plan audits were not documented and as a result care records were inconsistent and did not give an up to date reflection of people's most current needs.

Positive comments were received about the leadership of the home. Staff worked to the values of the home but were not always aware of what these values were. Staff felt supported and were confident in raising concerns to the manager.

Hamilton 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 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 15 August 2016 and was unannounced. The inspection team consisted of; three inspectors, an inspection manager, a specialist advisor in the care of Older People, Dementia Care, Tissue Viability and Palliative Care 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 expert had experience of caring for older persons and people who live with dementia.

Before the inspection we viewed the 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. We examined previous inspection reports, action plans from the provider, and other information we had received, including notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spent time talking to 12 people and five relatives. We observed care in communal areas throughout the day. We spoke with three registered nurses, five members of care staff, the administration manager, a unit manager, the deputy manager and the registered manager. We looked at eight care plans and records relating to people's care in full and four care plans in part to follow up on information. We looked at medicines and viewed other records in relation to people's care such as food and fluid, turning charts and progress notes. We looked at staffing records for nine members of staff which included recruitment, training and supervision records. We viewed additional supervision records for four domestic staff. We looked at records relating to the management of the quality and safety of the home which included accident and incidents, safeguarding concerns, complaints and compliments and resident and staff meetings and surveys.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe living at the home. They said they felt protected from the risk of abuse and from environmental hazards. One person said, "There are staff around all the time if you fall. I can't remember falling here but I did at home." Our observations on the day confirmed people were cared for in a safe environment.

At the inspection carried out on 22 and 26 January 2015 we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to medicines. We found there was a lack of clear protocols for as required (PRN) medicines which meant people were at risk of not receiving these medicines safely.

At this inspection we found the provider had taken some steps to address these concerns and had introduced clear protocol documents to be implemented and completed by staff for the administration of PRN medicines. However we found this practice was not embedded in the service.

For some people who required PRN medicines, particularly for pain or behavioural management PRN protocols were not always in place and there was a lack of recording regarding the effectiveness of these medicines. For example, records showed one person was given a pain medicine at regular intervals from 25 July 2016 to 14 August 2016; however there was no PRN protocol present for this person and no reason why the person required this medicine. Of the 49 occasions in which the person was given this medicine records showed only two entries had been recorded regarding the effectiveness of the medicines.

For a second person PRN protocols were in place for their behaviour medicines, however there was no evidence to show the effectiveness of these medicines had been recorded. For a third person a PRN protocol was in place for their pain medicines however there was no evidence to demonstrate this persons pain levels had been monitored. This meant we could not be certain if people were receiving their PRN medicines safely.

A failure to ensure the proper and safe management of PRN medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff administered medicines in a safe manner. Medicines were stored and disposed of safely. The medicines rooms on all floors were well organised and tidy. A refrigerator was available on three floors and the temperature checked and recorded daily to ensure medicines were stored according to the manufacturer's instructions. Medicines administration records (MARs) viewed were fully completed and up to date.

Prior to this inspection we received information stating there were insufficient staffing levels at the home to care for people safely. On the day of the inspection we observed care in communal areas throughout the day and found the care to be safe and in line with people's needs, with adequate numbers of staff present.

People and relatives confirmed there were enough staff. One relative said, "The staff ratio is excellent. It seems stable and I've never seen agency staff." Another relative said, "I come here at varying times and there's always someone around." Staff confirmed they felt enough staff worked at the home and one said, "Good levels of staffing, always have enough. If sick, another team member will cover." We observed a document on a notice board near the staff room showing uncovered shifts which were required to be covered due to planned or unplanned leave. Names of covering staff had been added to the list.

Staff rota's were in place for each of the floors which showed sufficient levels of staffing were provided at all times. Shifts for nursing and care staff were divided into a day shift of 8am – 8pm and a night shift of 8pm – 8am. A registered nurse was on duty on each floor during the day shift and two registered nurses were on duty during the night shift. The number of care staff varied for each floor due to the level of dependency for people on each of the floors. There was a staffing level dependency tool in place which identified there were sufficient staff available to meet the identified needs of people. Staff and the registered manager confirmed they no longer required the use of agency staff. Call bells were responded to promptly. Records showed people who required checking throughout the night were checked every two to three hours which was in line with the home's policy. This meant there were enough staff to meet people's needs and keep them safe.

Staff confirmed they felt people were safe at the home and demonstrated a good understanding of how they could keep people safe from harm. Staff could recognise signs and symptoms of potential abuse which included recognising unexplained bruising and marks or a change in behaviour. Staff confirmed they would report any concerns to the registered manager and were confident they would deal with their concerns. The registered manager was aware of their responsibilities when dealing with and reporting potential safeguarding concerns. They advised us of a safeguarding concern which was currently being investigated by an external agency. Records confirmed this and the Commission had been notified.

Safe recruitment practices were followed. We looked at recruitment files for nine staff. Appropriate steps had been taken to ensure staff were suitable to work with people. All necessary checks, such as Disclosure and Barring Service checks (DBS) and work references had been undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
People had a variety of risk assessments in their care plans to ensure they were supported to be as independent as possible whilst ensuring their safety and welfare. These included risk assessments on the Waterlow scale (this assessed the risk of pressure sores), falls, dependency scores, manual handling, nutrition and the use of bed rails. Risk assessments were reviewed regularly on a monthly basis. Equipment was in place for people who were assessed as requiring the use of equipment to ensure their safety and welfare such as bed rails, hoists and pressure relieving mattresses. Staff had received training in manual handling and pressure ulcer prevention. Staff were able to identify the risks to people and knew how to keep them safe.

Requires Improvement

Is the service effective?

Our findings

People and their relatives felt staff had the knowledge and skills to care for them or their relative and meet their needs. However observations showed staff were not always confident in dealing with people living with the advanced stages of dementia and their behaviours which could be deemed to be challenging.

At the inspection carried out on 22 and 26 January 2015 we found a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing. We found there was a lack of a planned and organised programme of supervision which meant staff were not supported in their responsibilities to deliver care and treatment to people safely. At this inspection there was no longer a breach of this regulation. We found staff were well supported, received regular supervision and appraisals with their line manager. The registered manager had implemented a staff supervision planner which demonstrated when staff had received and were due a supervision or appraisal.

Staff received an induction when they started work at the home. This induction programme included the completion of required training and working with an experienced member of staff to watch and learn techniques to meet people's needs. Staff also read people's care plans and risk assessments. New staff were subject to a probationary period in which their performance was reviewed at regular intervals.

A training plan was in place which identified the training staff were required to attend or had completed. Training courses were carried out regularly and staff attended and completed these courses. Refresher training was identified for staff who required updates and most staff felt they received enough training to care for people and meet their needs. However, staff did not always demonstrate the knowledge gained from this training or use the information they were given to support people effectively. For example for people who were living with advanced dementia and had behaviour which was deemed to be challenging, we saw the information staff had received was not put into practice in the home.

We observed staff in the communal area on the second floor, which is a locked unit, interacting with people who had advanced levels of dementia and behaviours which were deemed to be challenging. We saw that, although staff were present in the communal area where people were sitting, they did not engage with people unless a person moved or made an agitated sound. For example, we saw one person who looked agitated stand from their chair. We observed a care worker go over to this person and immediately assist them to the toilet. The care worker did not engage with the person. The care worker confirmed they had received training in dementia awareness but they told us it did not leave them feeling fully skilled to support people with advanced dementia and behaviours which were deemed to be challenging.

We heard a person asking to go home and they appeared slightly agitated. The person was approached by a domestic staff member who chatted with them, however the care worker present did not engage with the person. The care worker confirmed they had recently been employed and although had attended dementia awareness training was due to attend further training in this area in September 2016. This meant the training on dementia awareness and challenging behaviour did not give all the staff the skills or confidence to

support people with dementia effectively. However, it was evident throughout observations on the rest of the second, first and ground floors that staff had enough skill and experience to manage situations when they arose. We spoke with the registered manager and they said they would look into the content of the course and identify a more suitable training course.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Staff demonstrated a good understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They knew what to do when a person was deemed to lack capacity to make specific decisions about their day to day care. Staff were aware of the relevant professionals who needed to be involved and understood the process for holding best interest meetings to help make decisions about people's day to day care needs.
Staff asked people for their consent before carrying out any activity with them. People's care plans contained mental capacity assessments relating to specific decisions about people's care and deprivation of liberty authorisation forms were in place for people who were being deprived of their liberty.

People's care plans detailed people's specific nutritional needs. For example, 'needs weight boosting diet, supplements with drinks' and 'peg feed'. Malnutrition Universal screening tools (MUST) and nutrition risk assessments were in place for people who were at risk of malnutrition or obesity. When a person's weight was identified as a concern weight loss data would be collated for the person and included in the agenda for discussion at the daily 'flash' (quick) meetings between the registered manager, registered nurses and senior staff.

Fluid charts were in place and completed to help monitor people's fluid intake and avoid the risk of dehydration. However, we observed four people who were in bed in their rooms had been served drinks; these were left on their bedside tables. We observed this over a period of time. Only one of the four people were assisted to have their drink; the other three remained untouched. On the day of the inspection the weather was hot and sunny and the temperature in the home was very high. This meant these three people could have been at risk of dehydration.

Staff mostly encouraged people to eat and drink independently where appropriate and they made sure people were able to reach their food and drink. For example, we observed two care staff placing cushions behind a person so they would be more upright when eating. People who were not able to eat and drink independently were offered assistance. However, on one occasion we observed a person being supported to eat by a staff member, who was temporarily called away and the person began to feed themselves. This meant this person was being supported with their meals when they may be independent with this task.

We spoke with people about choices of food. Most people said they were happy with the food and drink on offer at the home. One person said, "You can ask for what you want. One morning I asked for bacon, egg and

sausage and I got it."

Staff confirmed people made their food choices for the day in the morning. Whilst this was appropriate for the majority of people, it was not suitable for those living with dementia. For example, we observed a care worker visit a person in their room with a breakfast menu and ask them if they could remember what they had ordered for breakfast the previous day. The person was unable to recall what they had ordered and the staff member said they would ask the person to reselect a choice or meal from the menu. This meant that although people were given a choice of meal people living with dementia may not receive their initial choice of meal because the gap between choosing and recalling was too great.

People's healthcare needs were met. People received regular health checks from GP's, dentists or opticians who visited the home. We saw in one person's care records they had requested to be referred to a physiotherapist as they wanted to start mobilising. This referral was made and other referrals were made promptly for people who required intervention from other health care professionals such as dieticians and speech and language therapy services Information and recommendations provided by these professionals were recorded in people's care plans and provided guidance for staff on how to ensure people's specific health needs were met.

A visiting health care professional arrived at the home to review a person's insulin following referral from the GP. The person's blood sugar levels fluctuated and the health care professional was impressed with the home's management of this person's diabetes which was more complex due to their reluctance to eat at times.

Good

Is the service caring?

Our findings

People and their relatives said staff were caring and they were happy with the care they received. One person said, "I am very happy here, I love the girls (female staff), they look after me." One relative had written in their relatives care records, "Staff are all helpful and kind." We received other positive comments such as, "When I first moved in one of the nurses acted like a mum to me and really looked after me." and "I get out of breath at night. If I ring the bell someone always comes and reassures me."

Positive comments had been provided by relatives and visitors on questionnaires which were readily available to be completed in the reception area of the home. One relative had commented, "I feel staff are always welcoming and helpful both to my mum and to me. Another said, "Always a positive experience, staff are excellent and always find time." A third relative said, "Staff are always friendly and helpful."

We observed good interactions between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff on the ground, first and part of the second floor. People, said they felt empowered to express their needs and received appropriate care. For example, we observed one person, who presented with behaviours which were deemed to be challenging, acting in an inappropriate manner in a communal area on the first floor. We noted care staff responded in a calm, kind and caring manner and helped to bring the person's behaviour to an end.

We spoke with people in their rooms. People had been given the opportunity to personalise their rooms and to bring in their own furniture from home if they wished. One person had a telephone in their room and answered a call from their family member whilst we were present.

Staff knew how to support people whilst keeping people's independence. One said, "If I am assisting with a wash, I will ask if the person would like to have a go and give them the opportunity." Another said, "Encourage people to use their walking aids on days when they don't always feel like it." People said they felt staff helped them to be as independent as they could be.

People who were able to make decisions did so and those who were unable were supported to do so. People said they were free to make their own decisions and staff respected these decisions. Residents meetings took place regularly where people were given the opportunity to express their views on their care, food and the home. People and their relatives confirmed they attended residents/relatives meetings. They told us they were able to discuss matters of importance to them on these occasions. One relative told us, "I attend these meetings and the chef does too. All suggestions are taken on board. For example there was a suggestion that everyone gets a daily newspaper. I know that's been done." One person said, "I attend residents meetings and what we suggest and the actions needed are always followed through."

People's privacy and dignity was respected at all times. We observed all staff knocking on people's doors before they entered and would give a greeting of either "Good morning" or "Hello" as they entered the person's room. We heard people being given choices on what they would like to wear, followed by friendly

banter and chatter. We observed care staff closed the doors of the person's room when they were commencing personal care. Staff gave us good examples of how they promoted people's dignity and privacy when they carried out personal care with them, such as, "Curtains always shut." ,"Cover people with towels, keeping half covered." and "Speaking through processes as you complete tasks."

Requires Improvement

Is the service responsive?

Our findings

We asked people and their relatives if they thought the care they or their relative received was responsive to their or their relative's needs. All were satisfied in this area almost all of the time. However, one relative told us, "We did request that our relative be up and ready to go one morning as we were taking them out but they weren't." People and their relatives felt involved in their care planning.

At the last inspection on 22 and 26 January 2015 we found care plans did not consistently or sufficiently detail all a person's needs to ensure their welfare and safety at all times. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded with regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found care plans were in place but continued to contain conflicting and inconsistent information. However people were receiving the most up to date care.

An assessment of needs had been completed on people's admission to the home and care plans were present in people's care folders. Care plans included information on peoples past and present medical history and on different aspects of daily living such as maintaining a safe environment, breathing, communication, nutrition, continence, pressure areas, mobility plans and mental health. People's care plans also included a personal evacuation plan (PEEP) which gave details on how the person should be evacuated in the event of an emergency procedure.

Care plans were personalised and contained people's preferences and sufficient information for care staff to meet people's needs. However we found some inconsistencies with the information provided. For example, one person's service user profile stated the person was reluctant to eat and required plenty of encouragement; however their nutritional assessment stated they were independent. This person's communication care plan stated they had no cognitive impairment however the person's medical care plan stated they had a diagnosis of vascular dementia. Another person's daily care records documented an incident of aggression but this had not been included on the person's behaviour management chart. We spoke to staff who showed a good understanding of these people's care needs and demonstrated they were providing care to people which met their most recent needs.

We found conflicting information with people's care plans and what was happening in practice. For example, one person's care plan stated they had no capacity to use the call bell. This information conflicted with rest of the person's care plan which stated they were able to use the call bell. We spoke with the deputy manager who confirmed this information was incorrect and had not been updated to reflect the person had the ability to use the call bell.

Another person's care plan stated they required their blood sugar levels to be monitored and recorded daily. However upon review of the person's blood sugar level we found these were now being undertaken once a month. We spoke with the registered nurse on duty and they stated the person's blood sugar levels had stabilised and as a result the person's care was changed to meet the NICE guidelines on monthly blood sugar monitoring of type 2 diabetes. The registered nurse agreed the person's care plan had not been

updated to reflect this change in their care needs. This meant people were receiving care which was up to date and met their needs however records were inaccurate which could put people at risk of receiving care that did not meet their needs.

Charts were in place for people who were at risk of pressure ulcers and required to be turned regularly to reduce the risk of the ulcer worsening. However care plans were unclear as to how often people required turning and records showed people were not being turned at regular intervals. For example, we looked at one person's daily notes of care and found the length of time between which they had been turned varied from 7 hours to 1 hour. Also records showed this person was not turned left or right for a whole 24 hours and spent a total of 7 hours on their back from 00:14am to 7:25am. This person had a grade 4 pressure sore on their bottom area and should spend as much time as possible off this area. However the person had a pressure area mattress in place and we could not find any evidence of additional impact to this person. For another person, who required pressure area care, their daily notes stated, "pressure area care given." However it did not state which position the person had been turned. We looked at records for 14 August 2016 and it showed the person was left on their back for the whole day and night. We spoke with this person and they confirmed staff turned them regularly. This meant people could be receiving the appropriate care with regards to their positioning but records did not show this.

The home employed a team of activity co-ordinators. During our visit, we observed three people were going on a day trip to the seaside. There were also a range of other activities on offer, both in group and one-to-one format. Some people took part in activities but we could not be sure the activities were meaningful to them. One person said, "Activities? Well they ask me if I want to go into town or on trips but I don't really want to. I'm happy here." A relative told us, "I've seen the list of activities. Church services, dog patting, knitting group. I think it seems to be geared to the ladies. There are a lot of ladies here." People who remained in their rooms or who were nursed in bed had little interaction with staff other than when their personal care was being carried out. We did not observe staff visiting people in their rooms or engaging with people in communal areas with activities. One staff member told us they did not think getting involved with activities was their responsibility as there was an activities co-ordinator. We recommend the registered provider and manager seek and review appropriate guidance on activities which are meaningful and supportive to meet people's needs and update their practice accordingly.

The provider had a complaints policy and complaints had been recorded, actioned and closed. The last documented complaint received was dated 14 July 2014. The registered manager confirmed they had not received any complaints since this date. People and relatives were aware of the provider's complaints procedure and were confident the complaint would be dealt with.

Requires Improvement

Is the service well-led?

Our findings

We asked people and their relatives if they thought the home was well led. All said they were happy with the leadership of the home. One relative said, "The manager is always available and sometimes mucks in with meals and medicines." Another relative said, "It feels like an extended family since the manager started. It's made such a difference with a real team spirit." Staff and other professionals also felt the registered manager showed good leadership and as a result things had improved within the home.

Quality assurance processes were in place and service quality audits took place regularly. Visitor questionnaires were available in the reception area for visitors to complete and these were looked at regularly and added to the agenda to discuss at the 'flash' (quick) meetings to discuss. Flash meetings were completed daily by the registered manager and leads of each floor to discuss concerns, issues and quality monitoring information. Other audits completed included, complaints, safeguarding concerns, medicines, health and safety and fire safety.

There was no documented evidence that care plans had been audited. The registered manager told us they completed care plan audits on an "ad-hoc" basis but did not formally record their findings. We found concerns with the inconsistency of information within care plans and the conflicting information contained within, and people's turning charts were not completed clearly and accurately. Although people were receiving up to date care; their records did not contain accurate and up to date information and people could be at risk of receiving care that did not meet their needs. The registered manager had failed to identify these concerns in their ad hoc audits.

A failure to maintain accurate, complete and contemporaneous records in respect of each service user is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The home's registered manager was registered with the Commission in May 2015. They had a visible presence within the home and knew the people and staff well. The registered manager said they tried to promote openness and transparency and always tried to make themselves available to staff. They made contact with all staff on a daily basis. Relatives were aware of who the registered manager was and felt comfortable discussing their concerns with them.

The registered manager advised us they were waiting for a new statement of values to be given to the home since the new provider took over in May 2016. However the registered manager said the staff should be working to the current values which were to promote dignity, respect and choice. Staff were unable to tell us the values of the home, however we made a number of observations throughout the inspection where staff demonstrated these values.

Staff confirmed they found the management team, which included the registered manager and deputy manager, very approachable and supportive. One said, "We are a good team. I can go to [registered manager], they are lovely and fair, like a manager is supposed to be." Another said, "It's a really friendly place to be." Staff felt comfortable to raise concerns, had a good knowledge of whistleblowing policies and

had confidence the management team would deal with their concerns.

There were regular staff meetings, which were held at various times to ensure all staff could attend. The minutes reflected that staff could raise any issues of concern and the action taken to resolve an issue was recorded.

Accidents and incidents were dealt with and reported appropriately. On the morning of the inspection a registered nurse informed us an accident had occurred with a person who was found sitting on the floor during the night. The person had sustained an injury as a result of a possible fall. We saw the registered nurse had completed the appropriate form identifying what had happened and what they had done. For example, they checked the person over and dressed their injury. The registered nurse advised they would pass this form to the registered manager upon their arrival. We checked with the registered manager later that day and they had received the accident form and started to analyse the information. We saw other accidents and incidents had been logged and were analysed to look to see if there could be any learning from these events.

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 The registered person did not ensure the proper and safe management of PRN medicines. Regulation 12(2)(g)

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 Records relating to the care and treatment of each person using the service were not accurate, complete or contemporaneous Regulation 17(2)(c).