Care Quality Commission

Caring Homes Healthcare Group Limited

Oak Manor

Inspection report

Dereham Road, Scarning, Dereham, Norfolk,
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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected Oak Manor on 19 November 2014. This home supports people with complex behaviour as a result of their dementia. Many of the people were in receipt of continuing health care funding due to their complex behaviour.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Relatives told us one of the things they valued about this home was that staff were able to support their family member throughout the duration of their dementia They were reassured and confident that the staff at the home would be able to manage whatever symptoms their relative developed and they would have their end of life care from familiar people in a familiar setting. Health and social care professionals we spoke with reported that staff managed people's very difficult and complex physical and behavioural problems well. They told us that they would recommend the home if they had a relative with advanced dementia.

Summary of findings

The Care Quality Commission is required by law to monitor the operation of the Mental capacity Act 2005 and Deprivation of Liberty Safeguards, and to report on what we find. We found that staff had a good understanding of this legislation and how to use it effectively it to protect people who could not make decisions for themselves.

Staff were trained and competent to do their job, and there were sufficient numbers on duty to meet people's needs. We found that people's health care needs were monitored closely and they were supported to access health care professionals when needed. People were supported to take their medicines as prescribed. People's challenging behaviour was managed well by staff and they were provided with appropriate stimulation and activity for their cognitive ability. However we found that the provider was in breach of two regulations as aspects of the premises did not meet people's needs well and not all areas of the home were clean, pleasant and hygienic. Not all interactions between staff and people were respectful or caring. You can see that action we have 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?
The service was not consistently safe.

People were kept safe by staff who recognised signs of potential harm and risk and knew what do to if concerns arose. Staff managed people's challenging behaviour well and used effective techniques to reduce their agitation.

People's needs were met by the numbers and skills mix of staff available to support them and received their medicines as prescribed. However people did not live in a clean or well-maintained environment.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People received their care from staff who had received good training and support for their role.

Staff had a good understanding of the Mental Capacity Act and therefore people who could not make decisions for themselves were protected.

People's health needs were monitored closely and they were encouraged to eat, drink and maintain a balanced diet. However some aspects of the home's environment were confusing for people.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People were cared for by skilled and caring staff who understood their individual needs. However the way that some people were supported to eat their lunch by staff was not dignified or respectful

People's friends and family were welcomed at the home and staff supported and encouraged these relationships.

Requires Improvement

Is the service responsive?
The service was responsive

People had their care assessed and kept under review, and staff responded quickly when people's needs changed.

Staff were willing to listen to people's concerns and responded appropriately to their complaints.

Good

Is the service well-led?
The service was well-led.

There was effective management in place which ensured the delivery of person centred care, supported staff learning, and promoted an open culture.

Good

Summary of findings

The quality of the service provided to people was regularly assessed to ensure it was of a good standard.	

Oak Manor

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 carried out to check whether the provider was 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.

The inspection took place on 19 November 2014 and was unannounced. It was undertaken by two inspectors and a specialist advisor in dementia care.

Before our inspection we looked at all the information we had available about the home. This included information from notifications received by us and the findings from our last inspection. Notifications are changes, events or incidents that providers must legally inform us about. We used this information to plan what areas we were going to focus on during the inspection. The provider also sent us a provider information return with information about what they did to ensure the service was safe, effective, caring, responsive and well-led. They also told us about any areas where they planned to make changes or improvements.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In addition to this, we spoke with seven people who lived at the home, five family members and three visiting health care professionals. We also spoke with a total of 11 staff including the registered manager, care staff, nurses, the cook and housekeeping staff.

We reviewed people's care records, staff records, and records relating to the management of the service. Following our inspection we contacted a number of health and social care professionals who knew the home well including social workers, two GPs, a community matron and mental health specialists, to obtain their views about the service provided. We also conducted telephone interviews with a further four relatives.

Is the service safe?

Our findings

Some areas of the home were not clean. Floors in some bedrooms we checked had not been swept fully and dust and debris had collected at the edges and under beds. The floor covering in two bathrooms was worn and coming away from the edge of the wall, allowing dirt and bacteria to accrue. Soft mats used to protect people from injury if they fell from bed were torn and one was spilling its filling onto the floor.

The laundry where people's clean clothes were stored was dusty and unhygienic. The main sink contained a build-up of lime scale in the plug hole and taps, creating an uneven surface where bacteria could accrue. Pipework at the back of machines was thick with dust, as was the vent behind the drier. Flooring, where we viewed people's clothes placed, was sticky and dirty, and shelving was rusty, making it difficult to clean. This meant there was an increased risk of cross infection for people.

We found broken pedal bins in two toilets areas. This meant that staff had to use their hands to open it, increasing their risk of exposure to infection. The main lounge floor was mopped twice during our inspection but both times this concentrated on the main floor areas and not the edges of the room. The staff member mopped the floor with a red mop which smelled of urine, leaving an odour in the room. We found thick dust under radiators in the main corridors. One member of the cleaning team was wearing a very soiled apron while cleaning in the dining room where people were eating breakfast.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two relatives we spoke with both stated their family member was safe at the home. They felt the staff knew people well and were able to predict and prevent some of their behaviours, such as shouting and hitting out at other people.

Staff we spoke with had received training about protecting people and were clear about their responsibilities. They showed a good understanding of the kinds of situations where people might experience abuse. Two members of staff stated that the main issue for safeguarding at the home was people's challenging behaviour and how it affected the safety of other people living there. Staff always took these incidents seriously and ensured they were reported accordingly so that further action could be taken if needed.

Records showed that staff had recorded any incidents or accidents that had happened in the home. These included incidents involving people's behavioural challenges. We looked at examples of these and found that staff had responded effectively and consistently with minimal intervention to keep people as safe as possible.

We noted posters on display around the home, giving people, visitors and staff information about how to recognise and report abuse. Information about how staff could raise their concerns or whistle blow about colleagues' practices was available in the staff room. This included the details of how to contact an independent whistle blowing hot line service. There had been a recent serious safeguarding incident at the home and the manager had responded swiftly and professionally to ensure that people were protected. The manager had also been rigorous about informing us, and local safeguarding teams of any incidents that occurred in the home so that, where needed, action could be taken.

Staff used nationally recognised assessments tools to identify potential risks to people's skin integrity and nutrition. Risk assessments were tailored to the individual and clearly identified steps to be taken by staff to minimise harm. We viewed staff implementing these risk controls during our inspection to keep people safe. There were falls risks assessments in place and where indicated the home used soft mats alongside low beds to reduce the risk of harm to people following a fall from bed.

One person told us, "There's always someone around and they bring me the bed pan quickly if I need it". Relatives we spoke to felt there were always enough staff on duty. One commented "I've never been anywhere with so many staff and they are all quick to come if needed.' One relative told us, "Sometimes I need to ask staff to change my husband's pad, but then it's done straight away". Staff told us that although it could be busy sometimes, generally there were enough staff to meets people's needs in a timely way. Staff were alert to people's whereabouts throughout our inspection and we saw they responded quickly to people's

Is the service safe?

requests for help. There was a designated carer who checked on people who were in their rooms every 15 minutes, to provide them with drinks and check their well-being.

The manager regularly reviewed staffing levels to ensure they were sufficient to meet people's needs, using a nationally recognised dependency rating tool. There were, on average, a minimum of two nurses and 14 carers on duty throughout the day to meet the needs of 58 people living in the home. In addition to this, staff were employed to support people on an individual level. At the time of our inspection six people were receiving one to one care as a way to manage their distressed behaviour and keep them, and other people, safe.

Staff we spoke with told us their recruitment had been rigorous and they had received good induction training to their new role, which included periods of shadowing an experienced worker before working on their own. We checked the personnel files for two recently recruited members of staff which contained the necessary evidence to show that they were suitable to work with vulnerable people.

Relatives we spoke with had no concerns about medicines management in the home. One relative told us, "Staff try hard to get his medicines right as they don't want him like a zombie". We observed two staff members supporting people with medication. Staff dispensed the medication according to the person's medication administration record (MAR) chart and supported the person to take the medicines according to their needs. They explained what the tablets were for and sought the person's consent. The MAR was completed accurately and cross referenced with the log sheet of all people living at the home. This ensured that everyone received their prescribed medications wherever they were in the home, as there was a quick method to check any omissions.

There were no staff signature omissions on the MAR charts, indicating that people had received their medication as prescribed. Reasons why people had not taken their medication were clearly recorded. However, medications were not stored according to the home's policy. Daily checks of the room temperature were recorded and the log sheet stated it should be below 25 C. However, since July the temperature had been recorded in excess of 25 C and had on occasion risen to 33C. During our inspection a portable air conditioning unit was emitting hot, rather than cool air which risked compromising the effectiveness of people's medicines.

Is the service effective?

Our findings

We noted many aspects of the home's environment that were responsive to the needs of people. Parts of the home had been transformed into 'reminiscence areas' and had been decorated with memorabilia and furnishings from days gone by. For example, one area of the home had been converted to an old railway station waiting room and one room had been converted to a 1950s sitting room. However, staff and relatives told us that this room was rarely used by people but staff meetings were held there. The manager informed us that people were only able to use the room when supervised by staff or relatives. There was no specific activity detailed on the weekly planner that made use of the reminiscence room. One staff member said she sometimes went into this room with the person she supported because it was quiet, but she had not used any of the reminiscence items.

Some aspects of home's environment were confusing with poor signage and orientation aids to help people find their way about. Corridors were long and similar looking and way marker signs were either too small or placed too high up, for people to see them easily. Corridors were also lined with unmarked doors, making the environment confusing for people and visitors. In one instance we heard a person calling from one room and knocked and walked in on them trying to use the toilet as there was no indication on the door that it was a bathroom. There were no signs to indicate where people's bedrooms were, or where key areas such as the main lounge, dining room or manager's office were. Very few rooms had any means for people to identify them as theirs. The handrail in some parts of the corridor was painted the same colour as the wall, making it very difficult for people with visual difficulties to see the rail and be able to use it.

Seated cushions were missing on two sofas, making them uncomfortable for people to sit on and difficult for them to get up from. The hand washing sink in the medicines room was blocked with equipment, making it difficult for staff to access, and the tap was running continuously.

The relatives we spoke with felt the staff came round and cleaned regularly but that the home looked 'tired' and 'uncared for'. One told us, "The place could do with a lick of paint". Although the main communal lounge had recently been decorated, we noted that the paintwork on bedroom doors and on bedroom walls was chipped, marked and unsightly. Some bedside cabinets and sink units in people's bedrooms were worn and chipped.

Although the home could accommodate up to 61 people, there was only seating for 20 people in the main dining room. This meant that not everyone could eat together and resulted in some people having their lunch in the same seat they had spent all morning, and others eating their lunch in small isolated areas around the home. We observed people walking into the dining room and, when they were unable to find a seat, returning to their chair in the lounge to wait for a space.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives we spoke with told us that staff had the skills and patience to support their family member. One told us that staff managed their family member's sometimes difficult and challenging behaviour particularly well. A community matron told us that the home's nurses knew people well; were very knowledgeable about diabetic care and dealt with people's challenging behaviour effectively.

Staff told us they received good training for their role. The home's activities co-ordinator had undertaken a specialist course for reminiscence for people with dementia, and also additional training from a leading dementia care specialist. He now delivered training to staff and reported that the impact of the training was that staff had more empathy and were more person-centred in the delivery of their care. Previously, staff had been more task focused in their engagement with people. Care staff also received four modules of a specialist dementia training programme, which were two day's duration each to help them better understand and support people living with this condition. The provider was in the process of setting up their own training programme for staff and had just become accredited with City and Guilds.

We found that experienced staff used a range of techniques to ease people's distress including distraction and diversion. Unfortunately two of the less confident staff members who were assigned as one to one carers where not so skilled and as they were working in isolation could not benefit from the role modelling of effective strategies from their more knowledgeable peers. This concern was

Is the service effective?

echoed by a mental health professional who told us that agency staff, who were mostly used for one to one support, were not as good at engaging with people and didn't have "The right approach".

Training records we viewed showed that staff had received a range of training to ensure they had the knowledge and skills to support people. One staff member told us they had been supported to undertake an NVQ level 3 in care, and another reported, "I have had lots of training. I have asked for additional training in taking bloods and this is going to be arranged."

Staff we spoke to understood how people were being deprived of their liberty, for example if they were receiving one to one care or were not able to come and go freely and why the safeguards were used. The manager in particular had a good knowledge of recent changes to the legislation. As a result she had recently applied for Deprivation of Liberty Safeguards to be implemented for all but one person at the home, as all required constant supervision and their ability to leave the home was restricted by staff.

We observed staff throughout the day seeking people's consent to provide care. For example, asking people if it was okay to put an apron on them, or move their chair.

Care records we viewed include assessments of people's mental capacity. One person who presented with disinhibited behaviour had detailed assessments and information from the Court of Protection concerning their mental capacity to make decisions about relationships and daily care. There was clear evidence that decisions which had been made contrary to their stated preferences had been done so in consultation with health care professionals and family, and had been made in their best interests.

There were effective records regarding the covert administration of medication to people. Letters from the GP evidenced that a 'best interest' decision had been made on behalf of people who had been assessed to lack mental capacity in this area. However, information about people's Lasting Power of Attorney (LPA) in records could be improved, as one care plan stated an LPA was in place but did not state whether this was for health and welfare or property and finance and who held the LPA.

Care planning around people's nutritional needs was robust. People were weighed monthly or more frequently if required. A screening tool was used to identify people at risk of malnutrition. Appropriate referrals had been made to outside agencies such as dieticians, and speech and language therapists if people required additional support. Weights of those identified at risk were checked by the manager weekly to ensure they were receiving appropriate care and support. We checked food and fluid charts for six people which were completed well and indicated they were getting good levels of food and liquids to keep them nourished and hydrated.

At lunch time people were offered a choice of two main courses (although both meals were pork). Meals were served according to individual need or preference. One person who had been losing weight was offered double portions of both main and dessert. Food was presented attractively including the pureed meals. People told us the food was 'tasty'. People with swallowing difficulties were assisted to drink and prescribed thickeners were used. The two staff we observed assisting people with lunch demonstrated a good knowledge of their needs and preferences and made the meal time a social occasion by engaging everyone at the table in conversation. However, occasionally forks were overloaded or the staff member did not observe the person had slowed down so offered the next mouthful before they were ready.

Staff worked proactively to reduce the number of falls people had. Detailed analysis was undertaken for anyone who had fallen twice in the space of a month; their GP was requested to give them a full medical review and a referral was made to the Community Matron for a falls assessment. The manager told us that the amount of falls people had experienced had reduced as a result. We spoke with the community matron who confirmed this was the case and reported, "Staff are good: they keep falls' diaries for people and analyse any patterns of falling".

We viewed the records for two people who had pressure ulcers. We found that these were being appropriately monitored and managed by staff. People nursed in bed were on air flow mattresses set at a suitable pressure for their weight. Repositioning charts were used to monitor position when people were unable to turn themselves, reducing the risk of pressure sores developing.

Records showed people accessed a range of health care services including the dementia intensive support team, psychiatry, speech and language therapists, and the community matron. We spoke to a number of these

Is the service effective?

professionals who spoke highly of the staff and the quality of care delivered to people at the home. They told us they received appropriate referrals from staff and worked well with them to maintain people's well-being.

Is the service caring?

Our findings

Not all staff consistently used language which valued people. One staff member shouted across the dining room, "Look, X (person using the service) is making a mess". Rather than letting their colleague know the person required assistance in a more caring way. We also observed two instances where staff assisted people to eat poorly, and did not communicate well with them, or explain what they were eating. In one instance, the staff member put too much food on the spoon and pushed it into the person's mouth. Lots of the food was going all over the person's mouth and chin as a result and the staff member did not clear this appropriately. In another instance we viewed a staff member assisting someone with their lunch some 35 minutes after it had been served to them. We asked the staff member if the food had been reheated in this time and were told it had not been, meaning the person had eaten cold food.

We received many positive comments about the quality and caring nature of staff from the relatives we spoke with. One relative told us, "The staff show great respect, understanding and kindness to people, I've never seen a carer or nurse snub or talk badly to anyone". Another reported, "I've looked after my husband for 55 years and staff really seem to understand that I can't give up the strings on him that easily". Relatives felt that both their family member, and their belongings were always cared for and one reported, "It doesn't matter what time of day you come he always looks good; clean and tidy, warm, dry and content".

We found that people's friends and family were welcome at the home, and that staff supported and encouraged these relationships. One relative told us, "Every member of staff speaks to you, knows who you are and who you're visiting". Relatives told us that staff at the home kept them well informed of what was happening with their family member and were good at ringing them when needed. One relative reported, "The nurses tell me everything what's going on"; another said, "they rang just the other day to check if mum wanted a flu jab".

The quality of interaction we observed between people and staff throughout our visit was of a consistently high standard, with staff showing warmth, respect and understanding of people. Staff complimented people on their dress and their contributions to activities. They encouraged people to be independent and congratulated them when they managed difficult tasks. Conversation was not task focused and added to the wellbeing of people by including them in social interactions and building shared interests between them. Staff used humour to engage people and aid compliance with their care routines.

Staff provided personal care with due regard for people's dignity and privacy and bedroom doors were always closed when personal care was delivered to people. Staff were alert to the privacy and dignity needs of people being hoisted in communal areas ensured their clothing remained in place as they were lifted. They spoke quietly to the person rather than announcing across the room what was happening. We observed a nurse changing a wound dressing for a person. She used language the person could follow to describe what she was doing and what had happened to her leg. She prepared the person for each stage of the process by explaining what she was doing and why. This person who had one to one care due to her disinhibited and disruptive behaviour remained calm and involved throughout.

Most people who lived at the home had limited ability to be involved in their care planning but they were involved in day to day decisions such as what to eat or what to wear when given a limited number of choices by staff. Care plans were individualised and clearly outlined people's strengths, needs and preferences. Information about people's daily preferences for activities of daily living were readily accessible to staff in a checklist format.

There was evidence of family and representatives involvement in some of the plans we checked. Most relatives told us they felt very involved in the day to day care of their family member. They felt their views had been listened to and knew there were relatives' meetings which they received the minutes to. Relatives reported that they had been given a copy of their family member's care plan and were involved in decisions about end of life care and advanced planning. Despite this, we spoke with one relative who told us she had not been involved in, or consulted about, her sister's mental capacity assessment or application to deprive her of her liberty. However, the manager told us that a letter had recently been sent to people's relatives and advocates to ask them whether or not they wanted to be involved in people's reviews, and if so how often.

Is the service responsive?

Our findings

Relatives told us they were impressed by how well the staff knew their family member, and responded promptly to their needs. One relative reported, "They manage my husband's stoma incredibly well". One person reported, "They know I like to sit near the window and they always save me a seat at lunch time."

Observation of staff conversations and interactions with people demonstrated a good understanding of their individual needs. Conversations with people with dementia were adapted to their level of understanding. Staff made effective use of body language and touch to communicate with people who did not fully understand speech. We observed two members using a hoist to move someone from an armchair to a wheelchair. They asked the person's permission and explained each step of the process they checked her wellbeing throughout and ensured the move was safe and comfortable.

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People's care plans included good information about managing their distress and aggressive behaviour. The plans were personalised and where possible identified individual triggers for the person and ways which that staff could try to calm them down. De-escalation techniques included distraction with an activity, snacks or drinks; being supported to a calm quiet space and being given time alone in a separate room. We saw these being used successfully by staff to keep people safe throughout our inspection.

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Care plans were reviewed monthly and updated as people's needs change. There was evidence that changes in people's well-being such as weight loss or increased behavioural disturbance were recorded and triggered relevant changes such as increased monitoring or referral to a GP, the Dementia Intensive Support team, or speech and language therapists.

Care booklets were used for specific people with pressure ulcers or other wounds. There was wound care diaries in place to ensure all dressings were changed according to the person's treatment plan. Photographs were also used to provide a detailed record. There was input from the GP and Community Matron and regular reviews were recorded. Where visiting professionals had provided strategies or treatment plans these had been recorded and used by staff to inform care planning for people.

Throughout the morning people were offered books, dolls and sensory items to promote their cognitive ability and reduce their distress. One staff member provided nail care to people in the lounge; they made this an enjoyable and social occasion involving several people. People were pleased with this care and proud to show off their newly coloured nails. Another person had been given a large teddy bear and was clearly enjoying talking and caring for him, as well as introducing him to passers-by. The home had a cat and also some rabbits, and one relative told us their family member greatly enjoyed petting them. The home had access to a minibus and each Monday took people out to the local village or places of interest. One mental health practitioner told us "Staff are very proactive at keeping people occupied". .

In the afternoon of our inspection a sensory session was facilitated by the activities co-ordinator. This engaged the most severely disabled people alongside their more able peers. The use of lights, music and film provided a range of sensory experiences and was calming. Staff effectively used the resources to engage people in conversation or where the person was unable to speak to provide stimulation e.g.

Is the service responsive?

with the use of fibre optics. One member of staff told us that he found having the main sensory items on a bespoke trolley was beneficial as it could be taken to any area of the home including people's bedrooms. The activity effectively brought people together, promoted their well-being and provided them with cognitive stimulation.

People felt confident about raising their concerns and suggestions for improvement to the service were taken seriously by staff. One relative told us, "I'd have no hesitation in going to Anne (the manager), she does listen to you, I would be happy and relaxed about raising any concerns I had". Another relative told us they had raised concerns about the state of the home's overgrown gardens, and that action had been taken to better maintain them. In response to people's concerns about the 'shabby' state of the furniture in the home, the manager had recently ordered new tables and chairs for the communal areas.

We viewed the minutes of a recent staff meeting where the home's complaints procedure and policy was discussed at length. Their importance as an 'invaluable tool' to improve the home had been stressed, giving staff a clear message that people's complaints should be taken very seriously.

We viewed the manager's response to two recent complaints that had been received. The manager had investigated each allegation professionally and in full, and had responded to the complainant in a timely way. A full apology had been given where the person's complaint had been substantiated, along with the action taken to avoid its reoccurrence. This showed that people's concerns about the service were taken seriously and responded to well.

Is the service well-led?

Our findings

The relatives we spoke with said they have confidence in the management of the home. They found the staff to be very open and their comments and suggestions were acted upon. Staff spoke highly of the home's manger. One described her as, "Very approachable, very pro-resident and hands on". Another commented, "I feel well supported and the management team are brilliant. The manager is lovely. I go to her if I have a problem and she will sort it."

The home had a stable management team in place. The manager had been in post for over five years and was a qualified registered general nurse with 13 years' experience of working with older people. She also held the Registered Manager's Award: a nationally recognised qualification for managers in health and social care settings. Health and social care professionals who knew the home all said their communication with the manager was good and they had a good relationship with staff there.

There was a management structure in the home that provided staff with clear lines of responsibility and accountability. The staff we spoke with felt the service had good leadership in place and reported they would have no concerns about speaking to the one of the management team if they wanted to. Staff morale was good with staff commenting on the good team work between them, and the family like environment in which they worked. A new member of the care team who had previously worked several agency shifts at the home had been encouraged to take on a full time position at the home. They were pleased they had done so as the management team had been very supportive of their learning needs and they had felt welcomed to their team. Support for staff was good and training records showed that they had received training in delivering safe and appropriate care to people. However, staff did not regularly have their everyday working practices formally observed or assessed by their managers to ensure it was of a good standard.

Staff had the opportunity to express their views during monthly staff meetings, their supervisions and via an annual survey. There was evidence that their suggestions were implemented. For example, one staff member told us they had complained about the state of their staff room. As a result this had been decorated and was now a much more pleasant space to relax and take their breaks in. The manager reported that as a result of the staff survey, staffing levels had increased, with five care staff now employed at night, and three nurses in the morning to better meet people's needs.

The manager had implemented an effective quality assurance system which included frequent checks of the environment, the quality of people's care plans, medicines management and people's weights. Detailed records were kept of any incidents or accident that had affected the well-being of people were kept and monitored weekly by the manager. However we found that there was little analysis of the record to ensure that themes could be identified and action taken as necessary to protect people from further incidents. The manager responded immediately to this shortfall and, by the end of our inspection, had started to fully analysis the incidents.

The manager was supported by a regional manager who conducted monthly audits of the quality of the home. In addition to this, the provider employed a specialist team of clinical auditors who regularly assessed the home and scored it on its performance. At the last audit the home had scored 84% and the manager had implemented an action plan to address the identified shortfalls in care plans and medication that the audit had highlighted.

The manager regularly sought the views of stakeholders, relatives and staff via an annual survey, and we viewed plans that had been implemented to improve the service as a result of feedback from these surveys.

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 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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider did not have an effective system in place to prevent, detect and control the spread of a health care associated infection.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People who used service and others were not protected against the risks associated with unsuitable and poorly maintained premises.**