Care UK Community Partnerships Ltd

Norfolk 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 27 June 2018 and was unannounced. Our last inspection was in September 2016 where we rated the service as 'Good' but made two recommendations about staffing levels and the caring nature of staff. At this inspection we identified breaches of the legal requirements in relation to staffing levels, person centred care and governance. You can see what action we told the provider to take at the back of the full version of the report.

Norfolk House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Norfolk House accommodates up to 76 people in one purpose built building. Care is provided across three floors which each have their own communal facilities and dining areas. One floor provided residential support to people living with dementia. Two floors provided nursing care to people with a variety of long term conditions and disabilities. At the time of our inspection there were 61 people living at the service.

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 2008 and associated Regulations about how the service is run.

There were not sufficient numbers of staff at the home to keep people safe. On a unit for people living with dementia, we identified a lack of staff presence to ensure people were kept safe. There were also shortfalls in relation to support and monitoring of staff medicines practice on one floor. Medicines were managed, stored and administered safely throughout the rest of the service.

Care was not always provided in a person-centred way. Care plans lacked detail, particularly around the support required for people living with dementia. Important information about people's backgrounds and their preferences with relation to end of life care were also missing. The provider carried out checks and audits but these had not identified and addressed the concerns identified on this inspection in a proactive manner. People also told us that they did not have regular contact with management.

People's healthcare needs were met by trained and competent nursing staff. We saw evidence of staff liaising with healthcare professionals where required and these staff had the support and training required to support them in their roles. The provider carried out checks on new staff to ensure that they were suitable to be working in an adult social care setting. Staff felt supported by management and we saw evidence of regular meetings to involve staff in the running of the service. The home environment was tailored to people's needs, but for those living with dementia interaction with the home environment was limited due to staffing levels. Staff ensured the environment was clean and there were robust processes in place to reduce the risk of the spread of infection.

Staff were kind, caring and committed to their roles. Care was provided in a way that involved people and staff offered day to day choices to them. Regular reviews were carried out to identify any changes to people's needs and the provider conducted surveys to gather feedback from people and relatives. Regular meetings took place to provide people with opportunities to make suggestions and we saw examples of recent suggestions being actioned by management. There was a complaints policy in place and management recorded and responded to complaints appropriately.

Risks to people were assessed and staff implemented plans to reduce hazards to people. People's independence was promoted by staff who were knowledgeable about how to empower people. Where incidents had occurred, appropriate actions were taken to keep people safe. Staff understood their roles in safeguarding people from abuse and we saw evidence of staff working alongside safeguarding teams where necessary to ensure people's safety. People were supported in a way that was respectful of their privacy and dignity. Staff sought people's consent and where people were unable to provide consent, the correct legal process was followed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not sufficient numbers of staff to keep people safe and staff did not always have time for meaningful interactions with people.

Medicines were managed and stored in line with best practice.

Risks to people were assessed and plans were put in place to keep people safe. Where incidents occurred, appropriate actions were taken in response.

The home environment was clean and the risk of the spread of infection was minimised.

Appropriate checks were carried out on staff to ensure that they were suitable for their roles.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training for their roles. Clinical staff had the right support to ensure they kept up to date with current practice.

People's dietary needs were met and food preferences were documented and responded to.

Where people had specific healthcare needs or required ongoing clinical support, this was carried out.

People were routinely asked to consent to their care and staff followed the correct legal process as outlined in the Mental Capacity Act 2005.

People's needs were assessed before they came to live at the service and the home environment was tailored to people's needs.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff that they got along well with.

Staff were respectful of people's privacy and dignity when providing personal care to them.

People's independence was encouraged and staff offered people regular choices to involve people in their care.

People were supported to maintain important relationships.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was not always personalised to people's needs where people were living with dementia.

There was a timetable of activities on offer but we noted these were not always accessible to people.

People's preferences with regards to end of life care were not always documented.

Regular reviews were carried out to identify changes in needs.

People's complaints were documented, investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider carried out checks and audits but these had not identified the shortfalls that we found during our inspection.

People did not always have ease of availability to management at the home.

Systems were in place to gather people's views and we found examples where this was responded to.

Staff felt supported by management and had regular meetings and opportunities to contribute to the running of the home.

The provider had notified CQC of important events, in line with their statutory duty to do so.

Norfolk 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.

The inspection was prompted in part by notification of three safeguarding concerns raised with CQC that raised issues with staff practice. We were also made aware of an incident relating to medicines management. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management medicines. This inspection examined those risks.

This inspection took place on 27 June 2018 and was unannounced.

The inspection was carried out by two inspectors, a specialist nurse, a pharmacist 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.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We asked for feedback from the local authority and the local clinical commissioning group (CCG).

Due to technical problems, the provider was not asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

As part of the inspection we spoke with 15 people and two relatives. We spoke with the registered manager,

the regional manager, two nurses and five care staff. We looked at care plans for nine people including risk assessments daily notes. We checked medicines records for 48 people. We looked at mental capacity assessments and applications to deprive people of their liberty.

We looked at a variety of checks and audits as well as records of surveys and minutes of meetings of staff, people and relatives. We looked at three staff files and checked records of staff training and supervision. We carried out observations throughout the day to observe staff practice and interactions with people.

Requires Improvement

Is the service safe?

Our findings

At our inspection in September 2016, we noted that staff were not always deployed in a way that meant people's needs could be responded to effectively. We made a recommendation about staff deployment. At this inspection, we identified continued concerns in this area.

We received mixed feedback from people on staffing levels. One person said, "Personally for me, yes there's enough staff." Another person told us, "They could do with an extra hand." Another person said, "There's not enough staff." Another person said, "It's bitty, sometimes I don't see them [staff] for ages." Another person told us, "Staff are often very rushed and I sometimes have to wait when I need them."

There were not always sufficient numbers of staff present to keep people safe. On a unit for people living with dementia, we identified times where there were not enough staff present to keep people safe. In the morning, we observed two people left for a long period in the lounge without supervision. We looked at one of the people's care plans and it said they required regular supervision, which we observed was not being fulfilled. During this time, the person also became verbally aggressive towards another person. The incident did not escalate but we noted there were no staff present in the room to intervene to keep them safe. We noted this risk was highlighted in the person's care plan but the lack of supervision meant staff could not intervene to prevent a potential incident from occurring. Another person was sat with a sensor mat in front of them as they were at risk of falls. Whilst the sensor mat would alert staff if the person got up and fell, the lack of staff in the room meant this risk could not be managed proactively to prevent the person falling.

Staffing levels limited opportunities for meaningful interaction between people and staff. On the unit for people living with dementia, four people sat in the lounge for most of the morning with a lack of engagement from staff. Staff came in and offered drinks but the interactions were task focused. People were sleeping upright in their chairs and there was a lack of conversation from staff. Staff were coming into the room periodically as they were also supporting people in their rooms. This showed staff did not have the time to spend with people on this unit.

On two units where people received nursing care, we observed that staff were able to respond promptly to calls and spend time with people. We observed staff spending time in people's rooms and call bells were answered within a reasonable time. However, we did receive feedback from people on these units that staff were often rushed when providing care, despite our observations being that there were enough staff on these units. One person said, "They (staff) have a job to do. They can't wait too much time."

We raised these concerns with management and the regional manager informed us that staffing levels were already under review to establish if increased numbers were required. After the inspection, the provider informed us a lifestyle co-ordinator would be allocated to unit for people living with dementia in the mornings. However, our findings showed that this concern was not addressed in response to our recommendation made after our inspection September 2016. We will require an action plan from the provider to provide timescales of when these concerns will be addressed.

The failure to ensure there were enough staff to safely meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were managed safely. Medicines records clearly showed people's photographs to enable staff to identify them before administering medicines to them. Staff were observed checking people's identities and medicine dosage before administering to them. MARs were completed accurately with no gaps and where people had specific guidance for 'as required' (PRN) medicines, there were protocols in place to guide staff on this. For example, one person had medicines for when they experienced pain. There was a protocol in place that detailed when these medicines were required and how often they should be administered. Staff were knowledgeable about this and records showed it was being administered in line with the prescriber's guidance.

Medicines were stored safely. Medicines were stored in secure areas which only staff could access. Regular checks were carried out on the temperature of storage areas to ensure medicines were stored within the temperatures set out by the manufacturers. On the day of inspection we noted that prescribed creams were stored within people's bathrooms where no checks were carried out on temperature. We informed the management of this and they addressed this on the day of inspection. During an observed medicines round, we did identify a shortfall in staff practice. This raised issues about the provider's systems for supporting and monitoring staff and we have reported on this further in the Well-led domain.

Aside from the risks we identified relating to staffing numbers, people's individual risks were routinely assessed and managed. Care plans contained evidence of risk assessments and staff kept accurate records to monitor risks. Risk assessments covered areas such as falls, pressure sores, nutrition and choking. Where risks were identified, action was taken to keep people safe. For example, one person was assessed as at risk of developing pressure sores because they were cared for in bed. To manage the risk, staff checked the person's skin daily and administered prescribed cream. The person had an air mattress to reduce pressure on their skin. Staff regularly supported the person to reposition and kept an accurate record of when they had done so.

Where accidents or incidents occurred, staff responded appropriately. The provider kept a record of all accidents and incidents and the actions taken by staff. Records showed that where people suffered falls, risk management plans were reviewed and new measures introduced where necessary. For example, one person fell twice in a month. Each time, staff documented that they had supported the person up and they had not been injured. After each fall, the person's risk assessment was reviewed and new plans were introduced to reduce the risk of further falls. The person had a sensor mat put in place to warn staff if the person got up. Staff carried out frequent checks of the person and records showed the regularity of falls had decreased. The provider carried out a monthly analysis of accidents and incidents to identify patterns and trends to learn lessons if things went wrong.

Staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding adults procedures and were knowledgeable about the process to follow in the event of a concern. One staff member said, "I would report anything straight to the nurse or the manager. I could also contact CQC or call the police if necessary." Records showed that the staff had escalated concerns they had appropriately and the provider shared information with the local authority safeguarding team and CQC where incidents had occurred.

People were protected from the risk of the spread of infection. Staff had been trained in good practice in relation to infection control and we observed them following this. For example, staff were observed using aprons when serving food to people. Staff also washed their hands before administering medicines to

people and we noted that personal protective equipment (PPE) was available throughout the home. Staff disposed of waste appropriately and there was a system in place to ensure that soiled laundry was managed and washed separately to other linen.

The home environment looked and smelt clean and people told us they were happy with the cleanliness of the home. There were domestic staff at the home each day and we observed them completing cleaning tasks throughout our visit. Domestic staff had a schedule to follow and signed off tasks as complete, to ensure accountability. Management carried out regular checks and audits of the cleanliness of the home.

Appropriate checks were carried out to ensure staff were suitable for their roles. Staff files contained evidence of references, health declarations, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS). The DBS holds a list of potential staff who would not be appropriate to work in social care. For nursing staff, we saw that checks had been carried out to ensure nurses were registered with the Nursing & Midwifery Council (NMC).

Good

Is the service effective?

Our findings

People told us that they were supported by trained, competent staff. One person said, "I'd say so [the staff are well trained]." Another person said, "They [staff] seem to be skilled." A relative told us, "I can't fault them [staff] in any way."

Staff were given appropriate training to equip them for their roles. Staff were knowledgeable and competent in their roles. The provider arranged training for staff in mandatory areas such as safeguarding, health and safety and infection control. Staff also received training in specific conditions such as diabetes and dementia care. The provider kept a record of all training completed by staff and tracked when training was due, records showed this was up to date. New staff completed the care certificate and staff had also completed additional qualifications in social care. The care certificate is a recognised set of training standards in adult social care.

Clinical staff had the support and knowledge required to provide effective care. Nursing staff had regular training to refresh their competencies in clinical procedures such as catheter care and supporting skin integrity. When we asked them about people's clinical needs, nursing staff demonstrated expertise in this area. For example, one nurse was able to describe how they made use of pain management systems for one person who was receiving end of life care. They described the training they had had and the process they used to assess pain for the person to identify if pain medicines were required. We noted that nursing staff were competent and knowledgeable where supporting people with catheters, wound care, diabetes and end of life care.

Staff had regular support from line management. Records showed that staff had frequent one to one supervision meetings that provided opportunities to speak with their line manager and identify any training needs. The provider kept a record of these meetings and it showed they were up to date and records of supervisions showed staff used these to discuss people's needs and their own performance. An annual appraisal was conducted and staff used these to set goals and track staff performance.

People's nutritional needs were met. Care plans contained information about people's favourite foods and the kitchen tailored to these. There was a choice available each day and the kitchen had a list of dishes they could prepare for people who did not want either menu option. Most people told us that they were satisfied with the food, however two people told us that the food could be better. We told the registered manager about this and they had not received this feedback before. We saw that there were regular surveys on the food and people were asked daily if they enjoyed their meals and their responses were recorded. These showed positive feedback had been received up until this point. The registered manager told us they would follow up on these concerns after our inspection.

Where people had specific dietary needs, these were planned for and met. People's care plans contained information about any allergies or specific dietary requirements they had. Where people needed specific support from staff to eat, care plans contained guidance on how staff could provide this. For example, one person had been seen by a speech and language therapist (SALT) and they had recommended the person

was served pureed foods and thickened fluids. This was in place to reduce the risk of the person choking due to swallowing difficulties. The kitchen had information about this person's dietary need and we observed them being served food in line with this guidance. Another person was assessed as at risk of malnutrition and weight loss. To manage this nutritional risk, staff weighed the person regularly and document their food and fluid intake. Records showed that the person's weight was being closely monitored and staff kept an accurate record of their food intake to inform healthcare professionals.

People's healthcare needs were met. Where people had specific medical conditions, care was planned around these and nursing staff met people's clinical needs. For example, one person was living with diabetes and required regular checks of their blood sugar levels. They also required a balanced diet and regular checks of their skin and feet as diabetes can affect these areas. Records showed staff were documenting the person's blood sugar levels and they were regularly visited by the community diabetes nurse. Nursing staff were knowledgeable about changes in the person's health and wellbeing that they should look out for. Care records showed evidence of regular appointments with the GP, optician and dentist.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff sought people's consent before providing care. Where people were able to give consent, this was documented and we observed staff asking people for permission before offering to provide them support. Where people were not able to provide consent, the correct legal process as outlined in the MCA was followed. For example, one person was living with dementia and they were assessed as lacking the mental capacity to make the decision to stay at the home. A best interest decision was made that involved staff and the person's relative that found it was in the person's best interests to stay at the home. As the best interest decision involved restrictions being placed upon the person, an application was made to the local authority DoLS team.

The home environment was suited to people's needs. The home was purpose built and was designed to ensure people could move safely around the home environment. Corridors and doorways were wide to allow access for wheelchairs. People had en suite toilet facilities within their rooms and rooms were spacious to allow room for wheelchairs or walking aids. For people living with dementia, there were pictures on the walls to encourage reminiscence as well as items for people to interact with. However, we did note that due to the lack of staffing people did not always get the support they needed to interact with the environment.

People received a thorough assessment before receiving support. Records showed people's needs were assessed before they came to live at the home. For example, one person had recently moved in to the home and their assessment showed they had specific dietary needs and required support with personal care. This information was included within the person's care plan.

Good

Is the service caring?

Our findings

At our inspection in September 2016, we identified that staff were not always providing care in a dignified manner. People were not offered choice and staff spoke about people in a way that was uncaring. We made a recommendation about staff practice. At this inspection, we found that staff were providing care to people in a way that was kind, dignified and caring.

People told us that they were supported by kind and caring staff. One person said, "I get to see the same staff. You get to know each other and you can chat. If I look down in the dumps, they won't chat, they're very good like that." Another person said, "They (staff) follow me around with a cup of tea." Another person told us, "Most staff chat to me, on the whole they're alright."

During the inspection, we observed pleasant caring interactions between people and staff. In the morning, one person wanted to watch TV in the lounge and staff spent time supporting the person to choose a TV channel. The person had difficulty expressing themselves and a staff member knelt down to their eye line and allowed the person time to make a choice. Later, staff were observed asking another person how they had slept, showing mindfulness that it had been a warm night. They talked about the hot weather and offered the person a variety of cold drinks. Staff that we spoke with were committed to their roles and wanted to make the people that they supported happy. One staff member said, "It doesn't feel like work, it feels like home and I treat people like I would my own family."

In the afternoon, we noted a pleasant atmosphere in a lounge as people and staff chatted whilst waiting for an activity to start. Staff were observed engaging in jokes with people which was making them laugh and created a friendly environment. People told us that staff made them feel comfortable and knew how to create a nice atmosphere. One person said, "This carer is always in a good mood. In ten minutes, he always has people laughing."

Staff involved people in their care. People were asked about their preferences and these were documented in care plans. For example, one person liked to have a later breakfast and this preference was documented and known to staff. People were regularly asked about their preferences at reviews and surveys. We observed that people were given day to day choices throughout the day. For example, as it was a warm day people were offered the chance to use the garden. Cold drinks were provided to people and staff gave people a choice of four flavours of drinks. Later, people were offered ice creams by staff.

People's independence was encouraged and promoted by staff. People's care plans reflected their strengths and provided guidance for staff on how to encourage them to be independent. For example, one person's care plan recorded that they could complete most personal care tasks themselves, but required some support from staff. A staff member we asked was knowledgeable about this. They said, "[Person] is quite independent but has some help in the shower. He can wash his legs and we help with other areas and check he is safe."

Staff were respectful of people's privacy and dignity when providing care. People told us that staff provided

care in a way that was respectful and dignified. One person said, "My privacy is respected, the cleaner knocks at the door." Wherever personal care was given, it was done discreetly and behind closed doors. Where staff came to support people in their rooms, we observed them knocking and waiting for permission before entering. People were dressed in clean clothes and were well-kempt. People said staff were mindful of their dignity and ensured they felt comfortable. One person said, "If I've been mucky, they change my clothes."

People were supported to maintain important relationships. One person told us, "My granddaughters bring me flowers and are always thinking of me." People and relatives told us that visitors were always welcome and catered for. During the inspection we observed relatives visiting people. Staff offered drinks and snacks to people and relatives whilst they spent time chatting. Relatives told us they were able to visit at any time and were offered meals if they visited at mealtimes. People's individuality and diversity was known to staff and support was provided accordingly. Staff were aware of specific cultural or religious needs that people had. However, we did note management was not always aware of people's religious needs. We have reported on this further in the Well-led domain.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive person centred care. One person said, "It's not what you really want, you make it so it's what they [staff] want." Another person said, "I haven't really been involved, I go along with it."

Care was not always appropriate to people's needs. On the unit for people living with dementia, staff were not always responsive to people's needs associated with dementia. We observed a DVD had been left on with the title screen left on a loop for most of the morning. This meant people listened to the same short piece of music repeatedly. Staff did not notice this and once it was highlighted to them, staff put a news programme on. However, the news story related to a fire and caused people to become distressed and staff did not pick up on the negative impact that this had on people.

There was a lack of care planning around people's backgrounds and wellbeing. Whilst staff intervened when people living with dementia became anxious, there was a lack of information on how best to support people in a way that made them happy. For example, we observed that one person was very distressed and started talking about a childhood incident. Staff intervened and tried to distract the person. The intervention was kind and provided some relief to the person. However, the person's care plan lacked information on their background and guidance for staff on what helped them when they became agitated. We noted another person's care plan said that they could become agitated but there was no information on the approaches staff could take to de-escalate situations when this person became anxious.

Another person had a world war 2 poster on their wall that had significance to their family. They told us about this family link to the famous poster that was of historical interest. When we checked the person's care plan, there was a lack of information about their background including this very significant fact. There were inconsistencies between units within the home on the level of detail in care plans and life stories. After the inspection, the provider sent information through to show work was underway to address this. Care plans were being updated and work was underway to write life stories with people. However, we will require further action to ensure people's care is planned in a way that is individualised and meets their needs.

We received positive feedback on the end of life care that people received. However, information in care plans regarding people's preferences and wishes at this stage of their lives was not always in place. For example, one person was not on an end of life care pathway but did have a long term condition that would require plans to be in place in the event of their health deteriorating. There was information recorded to state their family should be contacted and to liaise with healthcare professionals regarding anticipatory medicines. However, information on what was important or made this person feel comfortable was lacking from their care plan. This meant important information about end of life care was not gathered proactively, in line with recognised best practice and NICE guidance. Where people did not have a detailed end of life care plan and this was because they or their relatives did not wish to discuss this, this was not recorded. Therefore it appeared that no consideration had been given to planning how peoples wishes at the end of their life would be met.

People did not always have access to activities. There was a varied activity schedule in place that offered activities such as exercise, music, themed events and films. Feedback on these was activities was positive and we saw examples where people had requested activities and this had been actioned by staff. We also noted that people who were cared for in their rooms received visits from activities staff. However, our observations on the day were that not everyone was able to access activities. During our inspection, an activity took place in the garden. We noted that for people who were unable to go into the garden, there was a lack of alternative activity. This was noted on the unit for people living with dementia, where people remained in the lounge with limited interaction from staff.

The failure to plan care in a person-centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were regularly reviewed and aside from the instances where information was lacking, we did see examples where care plans were updated in response to changes in people's needs. For example, one person had recently been discharged by the dietician following improvements to their weight. In response, their nutrition plan was updated to reflect that they required less monitoring of their food intake and weight.

Complaints were investigated and responded to appropriately. There was a complaints policy in place which was displayed within the home and provided to people when they came to live at the home. The provider kept a record of all complaints and documented the actions taken in response. There had been five complaints in the last 12 months and records showed complaints had been looked into appropriately and a response sent to the complainants within the expected timescales.

Requires Improvement

Is the service well-led?

Our findings

People told us that there was a positive atmosphere amongst staff. One person said, "Staff are very friendly and polite." Another person said, "There's a really nice atmosphere."

Despite positive feedback about the staff culture at the home, our findings showed that work was required to ensure the service was consistently well-led. Whilst we noted there were checks and audits in place which we have reported on below, they did not identify or address the concerns detailed within this report in a proactive manner. We will require further action to be taken in response to our findings to ensure audits identify issues or concerns in a proactively.

There were instances where people were not involved in the service. We identified a lack of regular involvement from management in people's care. Whilst meetings and surveys were taking place, we did receive feedback from three people that management was not always visible within the home environment. One person said, "I don't see [registered manager] a lot. If I see him he always chats." We observed that the registered manager's office was located in an area where people would not regularly pass by. We saw the registered manager interacting with people throughout the home during our visit, however this did not match people's feedback.

We also noted that the registered manager did not have a good knowledge of the people living at the service. At the start of the inspection, we asked if there were any couple at the service or any people being supported to practice their faith. The registered manager told us there was nobody living at the home with these needs, but during our inspection we met a couple and we spoke with people who were practicing their faith. This was sometimes reflected in staff practice in that people did not always receive person centred care. For example, one staff member was carrying out a task and visiting people in their rooms. Rather than refer to them by name, the staff member had a list of room numbers and told us they only knew people's room numbers instead of their names. This showed that there was a culture at the home in which personalised care was not at always at the forefront of staff practice.

Staff did not always benefit from support and monitoring. During the inspection, we identified some shortfalls in practice during a medicines round. One person's medicines were left with them to self administer despite their care plan stating they could not administer their own medicines. The staff member signed the MAR without having seen the medicines had been taken and they told us this was how they usually supported this person. This showed that there had been a lack of observations to pick this up before our inspection. We raised this with the provider and they took immediate action in response and assessed the staff member's competency to find ways to support them. However, this was done reactively and we will require further action to ensure staff practice is monitored in a more proactive manner.

The lack of robust auditing, including checks on staff practice and the shortfalls in involving people in the running of the service were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Aside from the concerns we identified, there were systems in place to check and monitor the quality and safety of the care that people received. Records were kept of a variety of audits in areas such as infection control, health and safety and food. The provider also carried out regular visits to provide an external audit. The registered manager kept an ongoing action plan which recorded actions to be taken in response to audits. For example, a recent provider visit identified that MCA training needed updating and PRN protocols were not always in place. Our findings showed that these had both been actioned by management.

The views of people and relatives were gathered to inform decisions about the running of the service. Records showed that regular meetings and surveys took place to gather people's views to identify changes or improvements at the home. Where people made requests, these had been responded to. For example, people had requested a themed night and a BBQ and this had been arranged by management. Some people had asked to set up a Lifestyle Committee and the first meeting had been arranged for the day after our visit. This formed part of a series of improvements the provider was introducing to develop lifestyle workshops for staff to improve staff practice and develop improvements at the service in a way that involved people and staff. We will follow up on the impact of these improvements at our next inspection.

Staff felt supported and had opportunities to make suggestions about the running of the service. One staff member told us, "I really like working here, I can go to the manager with anything." Staff had regular meetings and records showed these were used to discuss practice and provide opportunities for staff suggestions. For example, at a recent meeting staff had discussed ideas for activities for people. A staff member told us, "We have a meeting every month and we have a handover every morning."

Management were aware of their statutory duties. Providers are required to notify CQC of important events such as serious injury, death or allegations of abuse. Our records showed that where appropriate, the provider had notified CQC. By notifying us of a recent medicines incident we were able to make a decision to bring forward this inspection to follow up on this concern.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always planned in a person-centred way. Care plans lacked detail about people's needs and what was important to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's audits were not robust enough to identify and address shortfalls we identified during this inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff at the home to keep people safe. Staff did not always have the supervision and monitoring they needed with regards to medicines.