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Rivendale Lodge EMI Care Home

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook an unannounced inspection at Rivendale Lodge EMI Care Home on 2 and 4 August 2016 to check that the provider had made improvements to previous concerns and to confirm that legal requirements had been met.

At the last inspection on 2 and 5 June 2015 we found the provider was not meeting the legal requirements in relation to consent. There had been no assessment to confirm people's level of capacity and their understanding and ability to consent to everyday care. The provider sent us an action plan and told us they would address these issues. At this inspection we found the provider is meeting this regulation.

Rivendale Lodge EMI Residential Home provides care and support for up to 27 older people who are living with a dementia type illness. At the time of this inspection 24 people were resident in the home. Everyone was living with a dementia type illness and some had additional health care needs associated with age and fragility. This included people with limited mobility and people with behaviours that may challenge others.

People, relatives and staff spoke highly of the service. However, we found people's safety was not always promoted. Guidelines for the safe and consistent application of topical creams were not in place. There was no information about the support people required to maintain their pressure areas. Where there were risks related to people's healthcare conditions such as epilepsy and diabetes there was no guidance for staff. Other records had not always been fully completed to demonstrate the care and support people received and required. These shortfalls had not been identified by the quality assurance systems.

There was a range of activities in place but staff had not received the training they required to ensure people who were less able to participate as part of a group, had enough to do throughout the day. We made a recommendation about this. Training updates were not always followed in line with the provider's policy.

Staff were kind and caring. They knew people well and had a good understanding of their individual needs. They responded appropriately to people's changing needs.

Staff understood the procedures to safeguard people from abuse. Records showed there were enough staff who had been suitably recruited working at the home. Mental capacity assessments were in place.

People were supported to maintain a healthy and nutritious diet, they were offered a choice of meals and staff supported them when eating, encouraging independence and promoting safety. People were supported by staff to have access to the appropriate healthcare professionals when they needed them.

There was an open culture at the home. People, staff and relatives told us they were able to discuss concerns with the registered manager at any time.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can

see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Medicines were stored and disposed of safely by staff who were suitably
trained. However, guidelines were not in place to ensure topical creams were administered in a safe and consistent way.

Risks were not always managed safely. There was no information about how risks relating to healthcare needs should be managed.

Staff were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

There was enough staff on duty who had been appropriately recruited to safely meet people's needs.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Mental capacity assessments were in place. Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Although staff had received training they had not received training to enable them to provide meaningful activities for people.

Staff ensured people had access to external healthcare professionals when they needed it.

People were supported to eat healthy and nutritious meals in a way that met their individual needs.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with kindness,

compassion and understanding.

Staff supported people to make their own decisions and choices throughout the day.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People were able to make individual and everyday choices and we saw staff supporting people to do this.

Staff had a good understanding of providing person-centred care and knew and understood people as individuals.

There was a complaints policy in place and people told us they would raise any worries with staff.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was an open culture at the home and the registered manager was well thought of.

The provider's quality assurance systems had not identified the shortfalls we found in relation to records

Rivendale Lodge EMI Care Home

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 was an unannounced inspection on 2 and 4 August. It was undertaken by an inspector 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.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records, staff files including staff recruitment, training and supervision records, medicine records complaint records , accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with seven people who lived at the home, five visiting relatives, and seven staff members including the registered manager, and two visiting healthcare professionals.

Most people who lived at Rivendale Lodge were unable to verbally share with us all their experiences of life at the home because of their dementia needs. Therefore the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff and watched how people were being cared for by staff in communal areas. This included the lunchtime meals. We also 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.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Rivendale Lodge. One person said, "I feel safe and happy here." Visitors told us their relatives were safe at the home, one said, "He is definitely safe. Staff are very watchful and they are always around."

We found aspects of the service were not consistently safe.

There were no medicine administration record (MAR) charts in place in relation to prescribed topical creams. The registered manager told us this was because creams were applied by care staff not staff who were giving people medicines. There were documents in people's bedrooms to show which creams people required and staff recorded when these were applied. Most creams were applied when needed and not regularly however the documents were not always clear or accurate. For example there were no body maps to inform staff where cream was required precisely or why. One person had been prescribed two different creams for their legs but there was no information about how staff would know which cream was required. Although staff recorded when they applied cream there was no audit or overview to show how often this happened or if the treatment was effective. Staff knew people well and had a good understanding of when and why the creams were required. However, the lack of documentation meant people could receive treatment that was inappropriate or inconsistent.

There were a range of environmental and individual risk assessments in place for example in relation to people's mobility, risk of falls and nutrition. Risk assessments had identified people were at risk of pressure area damage but there was no information in care plans about the support people required to maintain their pressure areas. For example, regular position changes and good continence care. Some people were living with health related conditions. These included epilepsy and diabetes. There were no care plans in place to guide staff. Staff recorded the blood sugar levels for one person with diabetes. There was information for staff to inform the GP if the person's blood sugar was above a certain level. However, there was no information about what were normal levels for this person, what would be considered low or any symptoms they may display if their blood sugar levels were unstable. There was no guidance in place for people who were prone to seizures. There was no information about what may cause a seizure to happen or how the person may be afterwards. Where people had a seizure there was no information about what had happened before the seizure or the duration of it. This information which could help staff identify if there were any patterns, and for health professionals to evaluate the person's epilepsy. Incident and accident forms had been completed when required. These included information about what had happened and the action taken immediately after. There was no information about any actions taken to prevent a reoccurrence or if care plans and risk assessments had been reviewed. The provider had not done all that was reasonably practicable to ensure plans were in place to mitigate identified risks.

These issues above are a breach of Regulation 12(2)(a)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding of the risks associated with supporting people. Pressure mattresses were

checked daily to ensure they were correctly inflated and the setting was correct. The home was clean, tidy and well maintained throughout. There were regular servicing contracts in place for example the gas and electrical appliances. There was guidance for staff on what action to take in case of an emergency and each person had their own personal evacuation and emergency plan. The home was staffed 24 hours a day and there were local arrangements in the event the home had to be evacuated.

There was a safe system to store, administer and dispose of people's medicines. A senior staff member who had completed their medicine training was allocated the administration of medicines on a daily basis. Medicines Administration Records (MAR) charts had been completed and signed by staff when medicines had been administered as prescribed. Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. There were protocols for their use. Staff administered medicines in a way that suited the individual. For example some people took their medicines with a drink and others, crushed and with a yogurt or other food. One person told us, "I get medicines and they watch me take them." Where people required their medicines crushed we found appropriate advice and guidance had been sought and documented from the GP and the pharmacist. When staff gave people medicines that had been crushed they reminded them they were taking tablets. Medicines were given individually from the storage cupboard and the MAR chart was signed after each administration.

There were enough staff deployed to meet the current needs of people living at the home. One person told us, "I think there are enough staff." A visitor said, "The staff numbers are good." The registered manager told us there were five care staff on duty each morning and four in the afternoon. There was also a member of care staff who worked during the afternoon and was responsible for activities and supporting staff with supper. There was a kitchen assistant who worked each morning and supported people at breakfast and lunch and with their morning hot drinks. In addition there was a chef, housekeeping and maintenance staff. Staff told us there were generally enough staff on duty. There were two staff on duty each night. Where possible a member of staff worked from 7-10pm. The registered manager told us they were currently recruiting for staff to work this shift. She told us current staff would cover the shift wherever possible. There was a member of staff in the lounge at all times and we saw people were attended to in a timely way. Staff were observed talking to people while they supported them and attending to them in an unhurried manner.

Staff had an understanding of safeguarding, they knew what constituted abuse and what actions they would take if they believed someone was at risk. They told us they would report any concerns to the registered manager or senior person on duty, they were aware of their own responsibilities in ensuring concerns were reported appropriately. Staff told us they would report concerns outside of the organisation, if for example, the senior person failed to act on their concerns. They told us they knew where to find the appropriate contact numbers if they needed them.

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the home. Staff files showed there was appropriate recruitment and appointment information. This included application forms, confirmation of identity, references and police (DBS) checks.

Requires Improvement

Is the service effective?

Our findings

We had carried out an inspection on 2 and 5 June 2015 where we found the provider was not meeting the legal requirements in relation to consent. There had been no assessment to confirm people's level of capacity and their understanding and ability to consent to everyday care. The provider sent us an action plan and told us they would address these issues. At this inspection we found the provider was meeting this regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications for people who did not have capacity and were under constant supervision by staff had been submitted. There were mental capacity assessments in care plans which informed staff that people were not always able to make choices. Mental capacity assessments did not include detailed guidance about how staff could support people to make decisions or how their consent was sought. However, this did not impact on people because staff knew them well and understood their care and support needs. Staff had some understanding of the MCA and DoLS and understood the importance of offering people choice. One staff member said, "If you ask someone what they want to wear they won't know but if you open the wardrobe some people can choose from there, others you would have to show a selection of clothes. Everybody has a different ability." We observed staff asking people's consent before offering care and support throughout the inspection.

People told us they were well looked after by staff. One person said, "They are good at their jobs," another person told us, "The best thing is they look after us all very well." We saw people approached staff when they needed support or assistance and staff responded to them appropriately. People told us, "The meals are very good," and we saw people enjoying their food. People had access to healthcare professionals when they need it, they told us they were able to see their GP when they wanted to.
Although there was an activity programme in place people didn't always receive activities that were tailored to meet their individual needs. Staff had not received any training in relation to providing person-centred activities. Staff did not recognise that time spent talking with people could be developed to provide personalised activities. For example there was always one staff member in the lounge but they did not always take the opportunity to engage with people. We recommend the provider ensures staff receive the training they require to meet the individual needs of people living at the home.

There was an ongoing training programme in place and staff received training in relation to infection control, first aid, moving and handling and dementia. Staff told us the training they received supported

them to provide people with the support they needed. Staff were encouraged and supported to undertake further training for example health related qualifications or care diplomas. They said if they identified any training that would help them to provide better care and support to people the registered manager would support them to attend. Staff supervisions took place regularly and provided staff with the opportunity to discuss any concerns, workloads and personal development. There were regular team meetings where staff were updated about changes at the home and reminders about their responsibilities. Staff told us they were supported by the registered manager. One staff member said, "We can always bring up issues, it's easy to communicate here."

Staff had the appropriate knowledge and skills to support and care for people. People and relatives told us staff were trained and understood the care people needed. One person told us, "They look after us and they are good at it." One relative said, "Staff are trained, since coming here my husband has improved immensely." We observed staff supporting people appropriately, for example when helping them to walk safely.

People were supported to maintain a balanced and nutritious diet they were offered a choice of meals however there were no picture menus or individual approach to offering food choices. Some people would only be able to make choices if shown the actual meals provided. The tablecloths were dark and heavily patterned. At lunchtime we saw people trying to find their cutlery however they were trying to pick up 'patterns' on the tablecloth. We identified these with the registered manager as areas that need to be improved.

Meals were freshly cooked each day. Records confirmed that people had their nutritional needs assessed and when risks were identified these were reflected within care documentation. For example, there was clear information about people who were at risk of choking and required a soft or pureed diet. Records were in place to monitor what people ate and drank at each meal, this meant staff were immediately aware when people were at risk of not eating or drinking enough and could offer alternative meals or drinks. People were weighed monthly so staff could identify anybody who was at risk of weight loss or malnutrition.

People were provided with a choice of hot and cold drinks, and snacks were served throughout the day. Their dietary preferences were recorded in the kitchen and information was in their care plans. The cook and staff had a good understanding of people's likes, dislikes and portion size. People told us the food was good. One person said, "The meals are very good and they would do something different for you if you didn't like what was offered." Meals were served in a way that reflected people's needs. We observed some people were given a plate with their food on it, but did not use a dining table or have the use of an individual table. Staff explained if these people sat at a table, due to living with dementia, they would forget to eat. However, if they were holding their plate they would eat their meal. People who did not use a table had the ability to manage their meal whilst holding their plate. We observed this person sat and enjoyed eating their meal independently. Where people required special diets for example pureed or fortified these were served appropriately.

People had their breakfast at a time of their choice and lunchtimes were relaxed occasions. People were able to sit where they chose and we saw people remaining within their friendship groups. Staff chatted with people as they served the meals and we observed people enjoying themselves. Meals were served in a way which encouraged people to eat together and people were able to eat at their own pace.

People were supported to maintain their independence at mealtimes through the use of specialised equipment and cutlery. One person who required pureed meals was served a large portion of food. Staff explained this person liked to eat independently but tended to spill some food. By providing extra food staff

ensured this person had enough to eat and drink. Some people required support, prompting and reminding to eat their meals and staff supported them appropriately and with kindness. We observed staff sitting on chairs and maintaining eye contact with people. They spoke softly and asked if they would like more food or offered alternative choices.

People told us they were supported to have access to healthcare services and maintain good health. We were told, "If you aren't well, they call the doctor in," and "When I needed to go to hospital, they came with me." Care records showed external healthcare professionals were involved in supporting people to maintain their health. This included GP, district nurses, optician and speech and language therapist. Healthcare professionals told us staff referred concerns to them appropriately when a need was identified. Staff told us about discussions they had with people's GP's to ensure they were receiving appropriate care. One person was unwell and we saw staff had contacted the GP on a number of occasions to discuss their concerns. Staff told us, "If we're not happy we will always contact the doctor. We want what is best for people."

Good

Is the service caring?

Our findings

People and relatives we spoke to were kind and caring. One person said, "The staff are kind and they are up for a laugh." Another person told us, "They treat you as you are human." A relative said, "The care is wonderful."

There was a warm and friendly atmosphere at the home. Staff were observant and attentive to people's needs. The SOFI and general observations showed interactions between staff and people were caring and professional. When staff approached people they did so respectfully and spoke to them using their chosen name. This meant people knew staff were addressing them. When staff were speaking with people they maintained eye contact. For example when supporting them at mealtimes and when they were sitting and chatting with them.

People were supported by staff that treated them with dignity and showed an interest in their welfare and views. Staff knowledge of people enabled them to communicate effectively and showed they understood the approach needed when caring for people living with a dementia. People were encouraged to make their own decisions about what they did and where they spent their time. For example people were not restricted from going into areas within the home and were asked where they wanted to sit. Some people liked to stay in the lounge and others liked to return to their rooms. The garden was accessible and had seating areas for people who wished to use it.

We observed staff chatting with people throughout the day. People and staff had conversations about topics of general interest that did not solely focus on the person's support needs. We observed one person was distressed, staff approached them and reassured them. They then suggested the person engaged in an activity to distract them. Staff explained this person was unwell which was why they were tearful. People were comfortable with the staff supporting them. They freely approached staff and chose to spend time in their company. We observed one person approach a member of staff and hold their hand. The staff member stroked the person's hand and spoke to them, the person then returned to what they were doing.

Staff had a good knowledge and understanding of people they looked after. They were able to tell us about people's personal histories, likes, dislikes and choices. Staff understood the importance of providing care that was tailored to meet people's individual needs. They supported people in sensitive, pleasant way that did not rush people and supported them in a way that promoted their independence. There was always one member of staff in the lounge and they were observant to people's needs, one person told us, "Staff who work here are kind and attentive." When people moved from where they were sitting staff observed them and attended to them if they appeared to need assistance. Staff noticed some people looked warm so they opened the windows and explained to people they had done so. Later, one person who was less able to communicate verbally was rubbing their arms. Staff asked the person if they were cold, the person said they weren't. The staff member gently touched the person's hand and their face and explained they looked cold and was making sure they were alright.

People's dignity was maintained and they were offered privacy. We observed staff discreetly asking people if

they required support with personal care. People were well dressed in clothes of their choice which were clean and well laundered. Staff knew how people liked to dress and supported them to do so. They told us about one person who liked to wear blue and we saw they were dressed in blue during the inspection. Bedrooms were personalised with people's own belongings such as photographs and other mementos. Bedroom and bathroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. Some people shared bedrooms and staff told us how they supported people to ensure their privacy was respected. There were dividing curtains in each room to help staff maintain this.

Good

Is the service responsive?

Our findings

People and relatives told us the care was individual and focused on people's individual needs. One person told us, "The staff take an interest in our care and I feel the care is right for me." A visitor said, "They look after him personally very well." Another visitor told us, "They (staff) respond to her awakeness and get her up or not to suit how she is."

People who were able enjoyed the activities that were offered. We observed groups of people engaging with staff playing bingo, participating in ball games and having fun reminiscing. There was a selection of music playing which people periodically joined and a sing along. One person enjoyed activities that they would have done at home such as folding towels. We saw this being done during the inspection. One staff member spent time with a person looking at a book and asking questions about it to prompt the person's memory. People were not isolated or spending time alone unless they chose to do so. Most people spent time in the lounge and staff regularly attended people who stayed in their rooms. The lounge was arranged so there were a number of different seating areas. This meant people could spend time in a different environment whilst still spending time with others.

People received the care and support they needed when they wanted it. We saw it was personalised to their individual preferences. The registered manager carried out an assessment before people moved into the home. This was completed in consultation with people and their representatives to make sure they could provide them with the appropriate care and support they needed. Pre-admission assessments were then used to develop the person's care plan. Care plans were reviewed regularly.

Care plans did not always include detailed information about people's care and support needs. However this did not impact on the care people received because staff knew them well. They had a good understanding of people as individuals, their daily routine, cultural and spiritual needs, their likes and dislikes. Staff involved people in what happened throughout the day. People were able to choose how to spend their day, what to eat and wear, they took part in activities if they wished. We observed people getting up at times that suited them. We observed staff supporting people in the way they required. When people moved around the home staff supported them appropriately. For example we saw staff supported people by placing their hand on the person's back to support them. Some people's mobility was variable and staff used the appropriate equipment dependant on the person's needs at that time. Due to their general frailty some people spent time in bed and staff regularly ensured they received the care they needed. Staff told us although some people were frail it was important they were able to get up sometimes. They told us, "We get them up when there is an activity we know they enjoy." They told us one person liked music and singing and would spend time in the lounge at these times. Another person got up each morning and staff reviewed at lunchtime whether they needed to return to bed after lunch.

Staff had a daily handover which included up to date information about people, any changes to their needs or individual reminders. Staff used this information to support the care they provided to people. They told us following a long time off work such as a holiday they would be given a more in depth handover to ensure they were aware of people's needs. Visitors told us they were kept updated about any changes or concerns

in relation to their relative's health or care needs.

Relative's views were sought through discussion and feedback questionnaires which showed people were happy with the service provided. There was a complaints policy at the home. People said they did not have any complaints at the time but they were able to speak to the registered manager or staff if they did. One person said, "If I had a grumble, I'd go to the manager." A visitor told us, "I've no complaints at all." Another visitor said, "They do listen and act on issues raised." People and visitors told us they were listened to and any worries were taken seriously and addressed. The registered manager told us any concerns were addressed as they arose which prevented them becoming formal complaints.

Requires Improvement

Is the service well-led?

Our findings

People and visitors spoke highly of the registered manager and staff. They told us the home was well run. One person said, "She (manager) is fun to have around." Another person told us, "It (the home) seems to be well run, the best thing here is you can go to any of them (staff)." A visitor said, "The manager is brilliant, she is always here and has positive energy." Another visitor told us, "We are delighted with this place, the general management is good and I do recommend this home." Staff told us the registered manager had an open door policy, she was always approachable and they could discuss any concerns with her. One staff member said, "She's good, she's a manager and a friend but she's still professional." Another staff member said, "We have regular meetings, we can bring up issues, communication is easy here, we're all mates and it's easy to talk."

However, we found aspects of the service were not well-led.

There were systems in place for monitoring the management and quality of the home but these were not always effective. Quality assurance systems had not identified all the shortfalls we found in relation to the mealtime experience and staff training. From the training plan we saw not all staff had received training and training updates in line with the provider's policy. For example, staff were required to update their safeguarding training annually. However, out of twenty four staff nine had not received safeguarding training in the last year. The registered manager told us further training had been arranged for these staff. Staff competencies were not checked in relation to medicines and moving and handling. Not all staff had received training in relation to MCA and DoLS and staff who had received this training, including the registered manager, had not received updated training since the Supreme Court judgement in 2014

They had not identified the lack of guidance in relation to how best interest decisions had been made for example where people shared bedrooms. They had not identified that some people who did not have capacity had signed consent forms to show they agreed with the care and support offered. The registered manager told us discussions took place with people's relatives and representatives however these had not been recorded.

There were no care plan or records audits to identify the shortfalls we found in relation to people's records. People's daily notes did not reflect the care and support people received throughout the day. When staff provided personal care and support to people they ticked a chart to show what care had been provided. According to the charts during June 2016 one person had received no mouth care, a second person had received mouth care twice and a third person had received mouth care four times. By direct observation and discussion we saw people had received the care they required but this had not been recorded. There was no audit system to identify this. Daily notes were brief and included comments such as "fine and settled," "no problems." This did not reflect what we had observed during the inspection.

Staff knew people well and were able to tell us about the care and support people needed. However, their care plans did not contain all the information needed to ensure people received good, consistent care. There was limited information about people's life histories and the care plans did not paint a picture of the

person as an individual. There were no care plans about people's hobbies and interests that staff could use to develop meaningful activities. Some people displayed behaviours that may challenge themselves or others. Their care plans informed staff to distract and reassure people but did not include any information about how this could be achieved. This could leave people of receiving inconsistent or inappropriate care.

Some people's mobility was variable; there was information for staff that people may need different support at different times. For example on occasions they may need to be supported by two staff with a handling belt, on other occasions they may need a hoist. There was no guidance about how the person may present for staff to determine which was the most appropriate way of supporting them. Where people required the use of a hoist there was no information about which sling staff should use. We observed staff supporting people who were walking using different techniques. This information was not included in the care plans. Some people required support to maintain their continence. Care plans informed staff if the person required the use of continence pads or prompting to use the toilet. There was no detail about what pads people used, when they may need to use the toilet. For example for those who were less able to communicate verbally there was no information about how they may express themselves.

One person recently admitted to the home did not have detailed care plans or risk assessments in place. Staff had a good understanding of how to look after the person. Information about their care needs was recorded in the daily notes however this was not easy to access as it took time to read and identify the person's needs. Staff had a good understanding of people's individual support needs however the lack of information could leave people at risk of receiving inappropriate or inconsistent care.

The quality assurance framework was ineffective because the provider failed to have effective systems and processes to assess and monitor the quality of the services provided and ensure people's records were accurate and complete. This was a breach of Regulation 17(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they enjoyed working at the home and felt they were supported, listened to and could raise any issue with the registered manager. They said that communication was good and there was a very good team spirit. Staff worked well together and communicated regularly with each other. Staff were aware of the Whistleblowing policy and told us they would use it if they needed to. Staff meetings were held on a regular basis and all staff had the opportunity to participate. Minutes were available for staff who were unable to attend.

There were building works due to take place at the home following our inspection. We were told this would increase the communal space available to people and provide a quiet room people could us. The registered manager was in the process of obtaining the appropriate information and completing risk assessments to ensure people were protected and disturbance to their daily lives was kept to a minimum.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Guidelines were not in place to ensure topical creams were administered in a safe and consistent way. Risks were not always managed safely. There was no information about how risks relating to healthcare needs should be managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not always accurate. The provider's quality assurance systems had not identified the shortfalls we found.