Romney Cottage Residential Care Home

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Inspection report

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Ratings

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

Overall summary

We inspected this service on 2 October 2014 and this was unannounced. We previously inspected this service in October 2013 and there were no concerns.

Romney Cottage provides care and support for up to 22 people who are living with dementia, have mental health needs or have substance misuse related needs. At the time of the inspection there were 21 people living there.

People told us that they felt safe and spoke positively about the support they received from staff. Relatives also said they felt their particular relative was safe and well cared for. One commented that the home was like "one big family".

The home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

Emergency procedures were in place but staff were not fully familiar with these. Important and appropriate checks were made of new staff before they commenced work but gaps in employment histories explored at interview were not well documented. Minor improvements were needed to ensure medicines were managed safely.

We found that newly employed staff did not receive an appropriate induction to ensure they had the right skills and had understood what they had learned, to support people safely and effectively and this could place people at risk. We found that whilst the home was guided by the principles of the Mental capacity Act 2005 to ensure decisions made on people's behalf were in their best interest they were not fully meeting the requirements of the Deprivation of Liberty Safeguards. People did not have enough meaningful activities to do during the week and at weekends. People's support at night was not fully recorded and this could lead to inconsistencies in delivery of support.

Some audits of environment and medicines were completed on a regular basis, but there was an overall lack of systems to assess and monitor service quality, those audits in place were insufficiently in depth to provide assurance that a good standard of quality in each area was being delivered. There were weaknesses in recording which meant that some information about how people were supported although carried out by staff was not recorded. Policies and procedures had not been kept updated to ensure staff worked to the most up to date guidance.

The providers visited regularly to talk with the manager about the home. However, systems were not in place to provide broad assurance that assessment and monitoring of quality of care was in place and would drive improvement of the home.

The home was kept clean and tidy. Communal spaces were comfortable, but overall décor throughout the home was tired and in need of refurbishment, and planned upgrades had not happened to the proposed timescales. Medicines were managed safely.

Staff were provided with a programme of essential and specialist training, to ensure that the care provided to people with a wide range of needs was safe and effective.

Throughout the inspection we saw examples of staff treating people with dignity and respect, being mindful of their privacy and interacting with them in a kind and friendly manner. Staff showed they understood people's individual needs and consulted with them about all aspects of their support and protected them from unnecessary risks. People told us there were enough staff to support them, more staff could be provided if dependency levels changed. There was a clear management structure in place and staff understood their roles and responsibilities

Staff understood about safeguarding and knew how to keep people safe. Records showed that the home used advocates for some people when important decisions needed to be made for them and there was no one else to assist them in making these decisions.

People and their relatives were encouraged to give their views about the home and their comments were analysed and acted upon to drive improvement. There was a complaints process in place and this showed that complaints were fully investigated and resolved in a timely way.

We recommend that consideration is given to current guidance regarding the development of emergency plans and also ensures that agreed places of safety are recorded clearly within this and made known to all staff.

We recommend that consideration is given to current NICE guidance regarding the management of medicines in care homes

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not always safe.

An appropriate range of recruitment checks were made of new staff but gaps in employment histories although explored were not documented. Emergency arrangements were in place but had not been fully made clear to staff. Cleanliness and hygiene standards had been maintained but not well documented. Some minor improvement was needed to the management of medicines.

Satisfactory arrangements were in place for the servicing and regular visual checks of fire equipment, and fire drills were held. Accidents and incidents were reported appropriately. There were enough staff on duty.

Individual and environmental risks were assessed without being overly restrictive to people. People said they felt safe and staff knew how to recognise abuse and keep people safe from harm

Is the service effective?

Requires Improvement

The service was not always effective

The induction of new staff was undeveloped and this could mean new staff may not have the appropriate skills to support people. People who were unable to consent to the restrictions in place did not have appropriate Deprivation of Liberty Safeguards authorisations in place.

Staff understood the requirements of the Mental Capacity Act 2005 and ensured decisions were made with regard to best interests.

Staff received up to date training and supervision. Staff understood and adhered to strategies for supporting people whose behaviour challenged others. People mostly enjoyed the home's food and had a choice about what and where to eat. People's health needs were attended to.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about the care staff gave. People said staff were kind and friendly and this was borne out by our observations of staff showing kindness and consideration for people's dignity. Staff were mindful of people's appearance both in the home and outside and ensured they maintained their preferred style of dress.

Relatives confirmed they were kept informed and staff supported people to maintain contact with their families and friends. The home used advocacy services for people who needed assistance with some decision making.

Summary of findings

People's motivation varied, but where able to staff supported people to achieve greater independence at a pace and at a time when they were happy for this to happen.

Is the service responsive?

Requires Improvement

The service was not always responsive

There was a lack of meaningful activities for people to do. Night support plans were not documented to ensure people received consistent support at night.

People had their needs assessed prior to admission to ensure these could be met. Care plans showed the most up-to-date information on people's needs, preferences and risks to their care and people had been involved in their development.

Changes to care were made known to staff through robust handover procedures and staff said communication in the home was good. People were able to raise issues that mattered to them in resident meetings. The complaints process showed the home responded to complaints in a timely manner and took action to address issues.

Is the service well-led?

Requires Improvement

The service was not consistently well led

There was a lack of assessment and quality monitoring systems, to provide assurance that care and support were always provided to a good standard. Proposed improvements were not progressed within timescales. Policies and procedures had not been kept updated to reflect best practice. and were only now being updated. Recording did not fully reflect the level of care and support people received.

People, staff and relatives spoke positively about the registered manager who fostered a culture of openness and support. There was a clear management structure.

People, staff and relatives were asked for their views on the service and these were analysed and action taken to address any shortfalls.

Romney Cottage Residential 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

This inspection took place on 2 October 2014 and was unannounced. It was carried out by one inspector.

Before the inspection we reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. The PIR 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.

Before we visited the home we checked the information that we held about it and the provider, this included notifications received and complaints. No concerns had been raised since we completed our last inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we observed how the staff interacted with people and each other. We looked at how people were supported during their lunch and during the course of the day and whether any therapeutic activities were happening. We also reviewed four care plans and risk information including pre-admission assessment information for two people, two new staff recruitment records, supervision schedules for all staff, induction and training records for all staff, menu information, medicine management records for six people, and quality assurance audits that the registered manager completed.

We spoke with 12 people and two visiting relatives. We also spoke with the home's registered manager, two members of the care staff, one domestic member of staff and the cook.

Following the inspection we contacted the commissioners of the service, a care manager and two health professionals who provide support to the home around mental health and continence and wound care issues, to ask for their views about the home. Feedback from three health and social care professionals showed no concerns. The need for improvements to the internal décor of the home was highlighted. Staff were spoken of positively for their dedication.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home, and this was also said by relatives we spoke to. People said there were enough staff to support them and they were happy living in the home. They said they felt able to raise concerns with any staff if they had them.

Records showed risks people may be subject to were individualised and recorded on their files, these were kept under review, and amended if a change occurred, and incidents were discussed with staff for learning purposes. Environmental risks that could affect everyone were recorded and reviewed when. Staff were made aware of what actions to take in the event of breakdowns in gas, electrical or water supply. An informal emergency plan also existed in regard to what would happen in the event of the home having to be evacuated. Staff were aware of the emergency plan and where to congregate away from the home if needed, but in the event of people not being able to return to the home overnight, staff were not aware of the informal arrangement in place with another home as a place of safety. Staff were confident that the registered manager was always contactable in any emergency.

We looked at the process for recruiting staff. Staff records viewed showed that there was a thorough recruitment process in place, to ensure that all necessary checks were completed prior to the staff member commencing their employment this included conduct in employment references, character references, a Disclosure and Barring (DBS) check (which checked whether the person had any previous criminal convictions and proof of personal identification. Although an application and interview process was in place. There were gaps in the employment histories of some of the staff files viewed, the registered manager told us these were explored with applicants at interview but this was not recorded in their records.

A health and safety audit of each bedroom and communal area was undertaken monthly, and priority risks were addressed but minor works for example in regard to damage to wall paper and other minor upgrading were not prioritised and took time to be addressed.

We looked at the arrangements for the management of medicines, and observed part of a medicine round. We asked the administering staff member, to talk through the medicine management process from ordering through to disposal and was satisfied that appropriate systems were in place for medicines to be managed safely. Prescribed medicines received in boxes outside of the pre-packaged dosage system used in the home, it is good practice to date and sign these upon opening to aid auditing of medicines but this was not done consistently.

Staff understood the process for reporting and responding to medicine errors. A record of errors was retained for each person and the registered manager checked this information for specific trends. A medicine audit was undertaken on a regular basis, but this was not sufficiently thorough to provide the registered manager with appropriate assurances that all aspects of medicine management from receipt, storage, administration and disposal were looked at to ensure this was undertaken appropriately.

The home was clean and tidy, people told us they were happy with the standard of cleanliness and a relative said she always found it “spick and span”. The home employed a housekeeper and a cleaner who between them had an established routine for cleaning through the home each week; these cleaning schedules were not recorded and relied on the familiarity of the two staff concerned. In discussion cleaning staff were able to describe a safe process for the cleaning of commodes that maintained good infection control, but this protocol was not recorded to ensure any new staff worked to the same process for cleaning commodes. The housekeeper was a member of the domestic team and completed regular audits of general cleanliness.

In discussion staff said they had received infection control training and records confirmed this. Staff had access to personal protective clothing which they were seen putting on when going to help someone with their personal care. Appropriate arrangements were in place for the management of laundry, and there was enough laundry equipment so that each person’s laundry needs could be accommodated in a timely manner. An overall infection control audit had not been implemented to monitor good standards were being maintained. This is a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

The provider had safeguarding procedures in place to ensure that any concerns staff or other people had about a person's safety were appropriately reported. Records showed that staff were reporting accident and incidents and that appropriate action was taken in response.

Staff spoken with demonstrated an awareness of safeguarding and several were able to provide examples of how they had reported concerns in regard to the poor practice of staff or abuse between people using services they had worked in previously. Staff told us, and training records confirmed that staff received regular training to make sure they stayed up to date with the process for understanding abuse, and reporting concerns they might have to the appropriate people or agencies. The manager spoke with staff about how they protected people through their everyday practice and discussed any incidents that occurred with them to share learning from this.

Staff told us that staff worked as a team and that communication between them was good, using handovers to share important information about people to ensure continuity of support. A new staff member told us that they had been impressed with the quality of handover information which was very thorough and they felt well informed about how every person was at the start of each shift.

The home had experienced some recent staff turnover after many years with an established team. A staffing dependency tool was not used, however, everyone we spoke with agreed that there were always enough staff to respond to people's needs and that staff had time to sit with people and talk. The registered manager told us that if someone needed more one to one support through illness there was flexibility within the staffing rota to ensure additional support was provided for how long it was needed. If a longer term need was identified a review of the persons needs would be conducted to establish if the home could continue to meet their needs, and if necessary seek funding for additional staffing hours. Staff were selected to work at the home on the basis of their skills and knowledge and all the new staff spoken with had previous relevant experience to bring to their role.

Staff demonstrated an awareness of whistleblowing (this is a process for staff to use if they are concerned about the practice of another staff member, the process protects their confidentiality). Staff spoken with felt confident about raising issues of concern with the registered manager. One staff member was able to provide an example of where this had taken place and changes in practice had occurred as a result. We checked records for the person concerned and found the improvements made had been sustained and were continuing.

Two people used air mattresses and community nurses and the home's staff took joint responsibility for checking these were set appropriately, no other specialist equipment was used.

Fire equipment was routinely serviced and visual checks made of fire equipment. Fire drills were held and each person had an individual fire evacuation plan. Annual servicing of gas and electrical installations was in date, water quality tests were conducted, and individual portable electrical appliances were safety checked.

At the time of the inspection there was no one who required support around diversity issues. However the home could demonstrate that they were able to support people with religious or spiritual needs and had made arrangements for those people who smoked to continue to do so in a smoking shelter within the grounds. They also took into account people's individual needs and ensured that medicine rounds did not impact on people's sleep, and people were not woken up to take medicines unless they were time sensitive.

We recommend that consideration is given to current guidance regarding the development of emergency plans and also ensures that agreed places of safety are recorded clearly within this and made known to all staff.

We recommend that consideration is given to current NICE guidance regarding the management of medicines in care homes

Requires Improvement

Is the service effective?

Our findings

People felt that staff supported them well. People told us they generally liked the food and were consulted about changes they would like to make, but did not always speak up. They confirmed that they had visits from the doctor, dentist and chiropodist and that staff called the doctor when they were unwell.

Records showed that staff induction was largely undeveloped, and primarily consisted of new staff familiarising themselves with the home routines and peoples individual needs. This meant that within 24 hours of commencing work, new experienced and those new to care were working as a full team member on shift. There were no competency based assessments of new staff, to ensure they had the right skills and were able to support people appropriately, or had understood what they had learned and read. This could place people at risk of being supported by staff that lacked the appropriate skills and is a breach of Regulation 23 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were restricted to staying indoors or making use of the garden area, unless they were accompanied by staff to go out. Staff kept entrances and exits to the home locked so that they could monitor who came in and left the building. This did not restrict people's movements around the home or in accessing the garden, and they could leave the home with appropriate supervision if they wanted to. The majority of people had the capacity to consent to the restrictions in place. The Mental capacity Act 2005 (This is a law that that protects and supports people who do not have the ability to make decisions themselves). Two people did not have capacity to understand the restrictions in place within the home and Deprivation of Liberty Safeguards (DoLS) (this provides a legal framework for restrictions that are in place) authorisations had not been applied for. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of staff had received Mental Capacity Act 2005 training. They gave examples of where best interest decision meetings had been called, or independent advocates had been requested to represent individuals when more complex decisions needed to be made in respect of care and treatment. On a day to day basis people made everyday decisions for themselves; for example when to get up, what to wear, what to eat and what to, do. In discussion staff explained how consent was pivotal to their support of people. They respected people's right to refuse consent to care, and reoffered this at a time more suited to the person.

People were consulted about what they ate and drank and were asked about their preferences at resident meetings. Weekly menus showed a good variety with an emphasis on fresh fruit and use of vegetables. People with specific health conditions like Diabetes had their food intake monitored and checks were made to ensure it did not place them at risk. People told us they did not always get specific dishes they liked to eat on the menu and when we asked why they had not requested these at resident meetings one person said, "You are conditioned to go along with what's offered". Another person disagreed with this statement and said, "You can ask for what you want, but you have to speak up". This meant that the home had not ensured that everyone was being enabled to make their needs known.

A staff training plan was in place and records showed that the majority of staff had completed all their essential skills and knowledge training for example, moving and handling, first aid fire safety training, infection control, safeguarding adults, and food hygiene and these were in date.

Staff told us and records confirmed that they received quarterly supervision (this is time staff have with the manager to discuss their training and development and work related issues), their overall work performance was discussed with them through the existing supervision process. The Registered manager was a visible presence to people and staff and spent time every day in the communal areas speaking with people and staff, she was able to observe staff practice during these times, and any issues that arose from this would be discussed with individual staff.

Discussions with staff and records viewed showed that restraint was not used and staff were not trained to undertake this. Some people could demonstrate behaviour that challenged others, but this was well understood by staff and the strategies staff used to support people were documented in people's support plans. The home's

Requires Improvement

Is the service effective?

registered manager and staff were aware of whether they could continue to meet people's needs and would refer people for urgent review, if their needs could no longer be met, or their presence was having a negative impact on other people's quality of life.

Relatives said they felt they were kept informed about the needs of their relatives and any changes to this. Staff said they worked as a team and felt that communication between them was good. A newer staff member commented positively about the quality of handovers, which they said took at least 20 minutes and ensured staff coming on shift knew about everyone's up to date needs.

Care records viewed showed that people were weighed regularly and that people were maintaining a healthy weight. Records showed that nutritional risk assessments were completed for people on admission, but not continued with unless a nutritional risk was identified.

We observed some people helping to lay cutlery and glasses for the lunchtime meal. The menu was recorded on a whiteboard in the dining room with an alternative if people wanted it. We spoke with and observed 13 people over the lunch period. Most people ate well and did not need staff assistance. The amount people drank was monitored by staff who recorded when people had a drink and these were offered at regular intervals. A drinks trolley was also left out for people to help themselves to hot or cold drinks.

A recent environmental health inspection had initially identified a number of areas for improvement, the kitchen and home's staff had worked hard to address these issues and on a return visit the home received the highest rating of five stars.

In discussion staff confirmed that people were supported to attend all routine and specialist appointments. Care records showed contacts with health and social care professionals including a dentist, reflexologist and chiropodist, who all visited the home regularly. People confirmed that their health needs were attended to and one person told us that they were due to see the dentist about their teeth soon. Contradictory responses were received from health and social care professionals. One said whilst they were generally satisfied with the way the home supported people. Another social care professional commented that the home's staff were very client orientated and quick to identify problems and involve them and community nurses when concerns were raised.

Records showed that the service maintained good links with the local mental health team for support and staff were able to give examples where they had been called in when people's mental health had deteriorated. Transfer information was in place in people's care plans in the event of their admission to hospital; this was accompanied with a copy of their current medicine administration record.

Some people had diabetes, the support provided from staff around this was not well documented in depth within care plans, but in conversation staff demonstrated a good understanding of how this was managed for each individual.

Good

Is the service caring?

Our findings

People we spoke with and their relatives told us they were happy with the care and support they received at the home. People said staff were kind and friendly to them and they had no concerns. A relative told us, "They are very caring, staff go that extra mile, he is so much better since he came here, he always looks well presented". Feedback from a social care professional that had contact with the home, also praised staff for their ability to settle people into the home, they commented, "The results they have achieved are amazing and it's only by the dedication of the staff and the manager".

The atmosphere in the home was calm and relaxed. Interactions between staff and people that we observed were kind and considerate of people's dignity and staff were jokey when appropriate with other people. We saw that staff undertook discreet observations of some people to offer assistance at the right moment, without taking people's independence away.

Staff spoke respectfully and fondly about the people they supported and the registered manager said that staff often brought in small gifts or a card for people when it was their birthday.

People were assisted with maintaining contact with their friends and relatives if they wanted to and staff told us they supported people to write letters and cards.

We observed people being kind to each other and when they spoke about things they might like to do this was inclusive of others in the home, not solely for their own benefit. A relative described the home as being "like a big family".

Observations also showed that people were asked by staff about their support needs and assistance was provided when needed. A staff member explained that when people said they were unwell, they usually had a day in bed if they wanted to, before the doctor was called unless symptoms indicated more urgent intervention was needed. She gave an example of a person who that morning had said they felt unwell and wanted to stay in bed, they were offered a bath and clean pyjamas and supported to go back to bed; they got up just after lunch and was feeling much better.

We observed some people taking responsibility to inform the registered manager when for example toilet rolls were running short in toilets, and offering to take spares around. The registered manager said that when the shopping was delivered a number of people usually offered to help carry it in and put away items. Others helped to make their own beds.

Relatives told us they were made welcome and we heard a visitor being offered a lunch when they visited. People who wished to follow their religion were supported to do so by a visiting local church representative.

The registered manager and staff understood about advocacy services and had used these previously. If people needed to make important decisions and needed help around this they were offered the option of an advocate and a referral would be made on their behalf.

Requires Improvement

Is the service responsive?

Our findings

Observations showed that people had little activity and they spent time in the lounges, their bedrooms, or the back garden where there was a smoking shelter. Whilst motivation to do activities could vary from day to day, most people spoken with said they did not have enough to do and they found it "boring". Many people told us they wanted to do more.

People told us they felt there was an over reliance on the television to fill their time and they wanted a more structured activity programme. Staff and people spoken with confirmed that some people did go out for walks every day when the weather was fine with staff support, but walks were often limited in length to the capacity of the person with the least mobility. As a consequence more active people often found their walk was kept very short. People also said they would enjoy going out in small groups to have coffee together in the local high street or other places in the local area. One person said that he felt confined to the four walls.

People said they wanted more flexibility about when they went out. We discussed with the registered manager how this could be taken forward. The registered manager showed she was willing to listen and consulted with people during the inspection to ask them to think of activities they wanted to do and to devise posters for this to inform everyone in the home, when these would be happening. There was a need to ensure that adjustments to activities offered were made for those people who were living with visual or hearing impairments or had mental capacity issues, so that they did not become isolated.

Night support plans had not been developed. These were important because some people had specific routines. A staff member gave an example where a verbally agreed strategy had not been adhered to; this had caused a setback in supporting a person during the night. Since then, staff told us that improved communication meant that all changes in care and support needs were fully discussed at handover, but people's needs still had not been recorded on their care plans. This could mean that people might not always receive the care or support they needed.

People's needs were assessed prior to their admission to the home; this ensured that their needs were understood and could be met by the existing skills and knowledge of the staff team. People were offered opportunities to come for tea, for an overnight stay or a month's trial before the final decision was made for them to live in the home.

The registered manager informed us that care records were in the process of changing to a new format and general updating. Care records viewed were a mix of the old and new formats. People's care records were personalised and made clear what people's individual needs were and how they were to be supported. Records showed that people's views and wishes about their individual preferences had been sought, included in their care plans, and reflected the support they received.

The registered manager said that people were given opportunities to raise issues at resident meetings, this was used as a support group but if issues were of a personal nature and could impact on the persons care plan they asked to see the registered manager after the meetings to discuss this. The role of key workers was being expanded to provide one to one time with people to provide them with a more regular opportunity to discuss their support needs in confidence.

People were given opportunities to express their views at resident meetings which were held several times per year; people said they felt listened to. There was also a Romney Cottage monthly newsletter to keep people up to date with news in the home.

A was a complaints procedure was displayed for people to use. This was in a format that most of the people could read. For people who needed support with reading the complaints policy, staff told us they always reminded people about the complaints procedure and explained the process for raising concerns.

We looked at the complaints record and noted that previous complaints had been appropriately investigated in a timely manner. Only one complaint was recorded for this year. The record of this complaint showed the investigations undertaken and actions taken by the service as a result. We asked staff how they learned from complaints. They told us that whenever an issue arose as a result of a complaint, accident or incident, the registered manager always fed back to staff and discussed with them how things could be improved to avoid any reoccurrences.

Requires Improvement

Is the service well-led?

Our findings

People liked the registered manager; they found her approachable and trusted that she would listen to them.

Discussions with the registered manager and staff indicated that only a limited range of basic audits were in place, for example written cleaning schedules were not in place in order to inform the cleaning audit that was undertaken, an infection control audit was still to be developed and the existing medicine audit was insufficiently detailed to provide assurance that all aspects of medicine management were being maintained to a good standard, care plan audits were not in place to ensure all relevant documentation was completed. There was no established system for the overall assessment and monitoring of service quality to assure the registered providers that people lived in a safe, effective caring, responsive and well led home. This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

A range of policies and procedures were in place, and staff spoken with told us that they ensured they supported people in accordance with the policies of the home. However, the registered manager acknowledged that many of these had become out of date and were not reflective of current good practice. As a consequence a new policy and procedure package had been purchased for the home that was helping the manager update policy information and records showed that a number of policies had already been adapted for use by the home. These were to be discussed with staff, to ensure they understood the policy content and whether this impacted on present practice.

Shortfalls in recording were evident including the recording on staff files information obtained about gaps in employment histories. Protocols for managing commodes were appropriate but not recorded to ensure other staff followed the same processes. Care and support delivered to people in regard to existing health care needs was not well recorded to ensure that everyone provided the same level of support. This is a breach of Regulation 20 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence that whilst the providers visited on a regular basis, they lacked a presence in the home, and staff and people in the home said they would welcome the providers showing more interest in them.

The registered manager informed us that she met with one or other of the provider's on a regular basis, when they discussed issues relating to the management and operation of the home. A record of these discussions with agreed actions was recorded by the registered manager and a copy sent to both providers. However, records of these meetings showed that no timescales for the actions highlighted were set and it was unclear how and when these matters were to be resolved.

The registered manager had drawn up a development plan for the home that focused on the most pressing environmental improvements. Mindful of resourcing issues, the plan had been staggered over a three year period. Works should have commenced in February 2014. At the time of the inspection only one highlighted improvement had been achieved and the home was already behind on the timescales proposed for completion of the rest of the works for the first year.

Discussions with staff showed that they thought the registered manager was helpful in enabling them to reflect on their practice and attitudes and to make changes.

Everyone clearly respected the registered manager who was a key figure in the smooth running of the home. Staff felt that she fostered an open culture that enabled them to raise issues and to feel listened to. Staff felt their comments were taken into consideration and the registered manager always gave them feedback about their ideas or suggestions even when it could not be pursued, and they valued this.

There was a clear staff management structure in place and staff spoken with understood their roles and responsibilities. Staff understood the reporting processes, but made clear that the registered manager was always approachable if they wished to raise anything with her. In discussion the registered manager showed a good understanding of the circumstances in which she would need to notify the Care Quality Commission (CQC) and had done so when such events occurred.

People, staff and relatives were asked to give their views about the service through questionnaires; response rates were not always good. Those received were analysed by

Requires Improvement

Is the service well-led?

the registered manager, and we saw where comments had been acted upon. However, the registered manager was keen to increase response rates generally and was looking at ways to engage people and staff more in the process.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were at risk because systems to monitor and assess the quality of the overall service they received to ensure this was safe and effective were not in place. Regulation 17 (1)(2)(a)(b). People were placed at risk because of shortfalls in recording in regard to care, staffing and operational records. Regulation 17 (2)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who were unable to consent to restrictions did not have appropriate Deprivation of Liberty Safeguards authorisations in place to support the use of restrictions. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were at risk because new staff were not provided with an appropriate induction to ensure they had the right skills and competency to support people effectively and safely. Regulation 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.