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The Manor Care Homes

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection visit took place on 30 June 2016 and was unannounced.

At our last inspection on 8 March 2016 we asked the provider to take action to make improvements and this action has now been completed.

The Manor Care Homes provides nursing and personal care for up 67 people. At the time of our inspection there were 32 people using the service. A number of people accommodated at the service were living with dementia and some people had complex physical needs. The service is located in Leicester and accommodation is provided over two floors with a lift for access.

The Manor Care Homes had 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.

Following our inspection in November 2015 the service was rated as 'Inadequate' due to serious concerns about the safety and well-being of the people who lived there. The commission placed the service in special measures and the provider agreed not to admit any new people until they had improved the care provided. At the time of this inspection we found that although there were some areas where further improvement was needed, significant progress had been made in the way that the service operated and in relation to the way in which care was being provided. Therefore the service has been taken out of special measures.

People using the service told us they felt safe and relatives felt their family members were safe. We found there was not always enough staff available to deliver people's planned care. The registered manager took immediate action to ensure staff were deployed more effectively to meet people's needs. Staff were safely recruited to help ensure they were safe to work in the service. Staff were trained in safeguarding people and knew what to do if they had concerns about the well-being of any of the people using the service.

Potential risks to people had been assessed, such as risks associated with the person's health condition and environment. Risk assessments were not always updated to reflect changes in people's needs and abilities.

The provider had ensured that effective systems were in place to ensure medicines were stored, administered and managed in a consistent and safe manner.

Staff received training and support that provided them with the knowledge and skills required to work at the service. We observed staff were confident and skilful in their interactions with people and talked with people as they supported them and put them at ease.

The provider had implemented a revised staff training and competency framework and nurses and care staff

said they were satisfied with the amount and quality of training they received. People were well supported with their healthcare needs and records showed they were seen routinely and when required by a range of health and social care professionals.

People were supported to have sufficient to eat, drink and maintain a balanced diet. Meals were served individually and staff provided sensitive assistance to people who required it. People's individual nutritional needs were supported.

We found the requirements to protect people under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had been followed. Appropriate paperwork was in place, including care plans, to demonstrate any restrictions on people's liberty were being lawfully applied.

People told us the staff were respectful and caring and supported them to maintain their privacy and dignity. People were offered choices and involved in their own care. We saw staff supported people to maintain their independence.

Staff were knowledgeable about the people they supported and demonstrated that they knew their likes, dislikes and interests. Care plans had been developed to focus on people as individuals and described their choices and how they wanted their care to be provided.

Staff had introduced a new programme of one-to-one and group activities. Records showed and we saw that these were well attended and people told us enjoyed having more to do.

All the people using the service, relatives and staff we spoke with during our inspection said the service had improved. The provider's quality assurance system had identified where some developments were needed to the service, although we saw that improvements were not always identified or completed within timescales. Further improvements were needed to record-keeping and to ensure audits were consistently applied.

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.

Staff were not always deployed effectively to meet people's individual needs and keep people safe. When we raised this with the registered manager, they immediately took action to re-deploy and increase staff in the service. This helped to mitigate the risk to people's safety from insufficient staffing. Assessments of risks were not always effective as not all assessments reflected changes in people's needs and abilities. People's medicines were managed in a consistent and safe manner. Staff understood how to act if they were concerned that people were at risk. Recruitment systems helped ensure new staff were safe to work with people.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to provide the care and support people required. The registered provider followed the requirements of the Mental Capacity Act 2005 (MCA). People had sufficient to eat and drink and were able to contribute to menu planning and feedback on the quality of meals served. Staff understood people's health care needs and referred them to health care professionals when necessary.

Is the service caring?

Good

The service was caring.

People and their relatives were happy with the care they received from the service. People were treated with kindness and their privacy and dignity was respected. Staff encouraged and supported people to make choices and maintain their independence.

Is the service responsive?

Good

The service was responsive.

A range of activities were provided for people and the service was

developing an activities programme to meet people's individual interests and preferences. Care plans and practices showed that people's care and treatment was individualised. People's care was reviewed with them and, wherever possible, those who were important to them. People knew how to complain about their care and complaints were managed in accordance with the provider's complaints policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems were in place to assess, monitor and improve the quality of care but these were not always effective or applied consistently. There were regular opportunities for staff to share their views about people's care. People, their relatives and staff spoke positively of the registered manager and their role in managing and improving the service.

The Manor Care Homes

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 30 June 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. A specialist advisor is a person with professional expertise in care and treatment. The specialist advisor for this inspection was a pharmacist. 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 we reviewed the provider's statement of purpose and the notifications the provider had sent us. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about. We also spoke with local health and social care commissioners, responsible for funding people that used the service, and asked them for their views.

During the inspection we spoke with six people using the service, three relatives, one nurse, seven care workers, one chef, the clinical lead nurse and the registered manager.

We looked in detail at the care records of six people using the service and a range of documentation about the care, staffing and quality assurance for the service. These included records pertaining to the management of complaints, accidents and incidents, staff deployment and minutes of meetings. We also looked at recruitment and training records for eight members of staff.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in 2 and 3 November 2015 we found the provider had not ensured that people were being protected from the risks associated with the unsafe management and administration of medicines in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made.

The provider had appointed a clinical lead nurse who had helped to introduce a new system for the management of people's medicines. The clinical lead was also in the process of re-training staff and implementing random and regular medicines audits. This helped to provide nurses with the knowledge and training they needed to ensure people received their medicines safely.

Medicines, including controlled drugs, were kept in a lockable facility designed for the purpose of storing medicines safely. Controlled drugs were stored safely and records showed these were being regularly checked and counted out and signed for by two registered nurses. This showed that nurses were following the provider's policies and procedures to ensure people received their medicines as prescribed. We saw that opened bottles of liquid medicines were marked with the date of opening. This is important to ensure the medicine was safe to use as some medicines have a limited expiry date.

We looked at a sample of ten Medicine Administration Records (MARs) and found records were accurate and correctly completed in line with people's medicine care plans. MARs included information about people's allergies and their preferences for support to take their medicines. Where people were prescribed topical medicines, such as creams and ointments, these were recorded on a body map to guide staff on the correct area of application. We saw that where medicines were prescribed to be given to people as and when needed, there was a clear written protocol to guide staff to provide support safely and consistently. For example, where people required pain relief medicines, we saw protocols were in place to ensure doses of medicines were not administered within four hours from when they were last given and were only given when people needed them. This meant that people could be confident that they received their medicines as they needed them and as prescribed.

We observed a nurse supporting people to take their medicines during our inspection visit. We saw this was done safely. The nurse approached people individually and asked them if they would like to take their medicines, telling them what they were for. People were given time to take their medicines in the way they wanted to and no-one was rushed. One person told us, "[nurse] is a marvellous person. [Name] gives me my medication regularly to ease the pain. They make sure I am never in any pain. We later observed the nurse talking with the person and asking them how their pain was and checking if they needed further pain relief.

We looked at the use of covert medicines. Covert medication is the administration of any medication in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the person is unknowingly taking medication. We saw that where relevant the person's GP had authorised

the use of this and the service had sought advice from the local pharmacist in administering the medicine. The clinical lead informed us that the person was not currently declining their medicines and therefore nurses were not administering medicines covertly. The registered manager agreed to review the protocol to ensure it was still relevant and appropriate for the person's needs.

We looked at staffing levels in the service to check whether staff were sufficiently deployed in the service to keep people safe. One relative told us, "I visit regularly and I'm never unhappy about the care and support. I have no concerns." One person told us, "I have the call bell and the staff come to help when I need them." Another person told us that staff were not always productive in their roles and told us they were concerned that people did not always receive the attention they needed when they needed it. A staff member told us, "We are sometimes short of staff. Not at any particular time, it's usually that staff ring in sick." We observed how staff were deployed within the service. We found that whilst there were sufficient numbers of staff to meet people's needs in one unit, there were not enough staff to keep people safe in another unit.

We saw that some people needed support from two members of staff to meet their care needs or required constant supervision to keep them safe. Some people, due to their health conditions, were reliant on staff to support them to change position to reduce the risk of skin damage through prolonged pressure. A staff member told us that they had tried to summon staff assistance to enable them to support a person in this way but had been unable to do so. We observed they were unable to support the person within the correct regular time interval shown in their care plan as there were not enough staff. We found gaps in some people's care records that needed to specify when staff supported them to change their body position. Staff told us that people sometimes had to wait longer for assistance to change their position if staff were busy elsewhere in the unit. We raised this with the registered manager who immediately responded to our concerns by re-deploying staff and increasing staffing levels to ensure people were kept safe in the unit. This helped to mitigate the risk to people's safety from insufficient staffing.

We saw that potential risks to people's safety were assessed before they received care. These included risks associated with the person's health conditions and environment. Care records identified potential risks and measures staff needed to follow to reduce potential risks. However we found that not all people's risk assessments had been updated following recorded changes in their health conditions. For example, risks assessments for one person did not reflect that the person could no longer weight bear or help themselves to move following changes in their health condition. This meant people were at risk of receiving unsafe care because staff who did not work regularly in the service may not have the information they needed to keep people safe. We raised this with the registered manager who told us they were in the process of updating people's care plans and would ensure person's care records were updated following our inspection visit.

Staff showed they were aware of how they should report safeguarding concerns (protecting people who use care services from abuse). One staff member told us, "I have done safeguarding training and I understand the need to report things and check." Another staff member told us they had completed safeguarding training through e-learning and were due to complete a more in-depth course as part of their induction training. We saw that information to support people to understand safeguarding was displayed around the service. This included contact details of relevant external authorities if people wished to report concerns.

People's safety was supported by the provider's recruitment practices. We looked at staff recruitment records which showed relevant employment checks had been completed before staff worked unsupervised at the service. This included checks of staff identity, previous employment and checks with the Disclosure and Barring Service (DBS). DBS checks are carried out to support employers to make decisions if prospective staff are safe to work with people using the service. Records showed that the registered manager carried out periodic checks of nursing staffs' professional registration status with the appropriate professional

regulator. This helped to ensure that nurses employed at the service were deemed fit to practice and provide nursing care to people.

The registered provider had a recorded system for monitoring and investigating accidents and incidents. We reviewed these records and saw an investigation report was written for each incident, including the action taken to resolve the incident to identify and respond to any trends and patterns. Examples of previous action taken following an incident included reviews of people's medicines and falls intervention plans to ensure that measures were put in place to reduce the risk of further incidents or accidents to people.

We saw there were systems in place for the maintenance of the building and equipment. This included maintenance of essential services, which included gas and electrical systems and appliances along with fire systems. Records showed that these checks were up to date.

Good

Is the service effective?

Our findings

People were cared for by skilled and competent staff. One member of staff told us their training had improved over recent months. Another staff member told us, "I have done my mandatory training and the training has been good. I have also been supported to undertake additional training to develop myself."

The registered provider ensured staff had undertaken the training they needed to care for people using the service. The registered manager provided us with a training plan for care and nursing staff for the next twelve months. We saw that the plan included care and clinical training. The registered manager also managed an electronic training matrix to monitor compliance with training and ensure staff training was kept up to date. We saw that they kept training records up to date. New staff were supported to undertake the Care Certificate during their workplace induction. This is a national qualification that supports care staff to develop the skills, knowledge and behaviours to provide quality care.

Staff were well supported to carry out their individual roles. They told us they felt the registered manager and clinical lead nurse were approachable and supportive. Staff had regular one to one supervision and appraisal with their line manager. We saw staff were supported to discuss issues relating to their work and performance and were provided with feedback following observations on their working practices. The registered manager had recently introduced competency framework observations for care staff and clinical staff and these were in the process of being implemented at the time of our inspection. This meant that both the registered manager and the clinical lead nurse could monitor and assess staff working practices to set standards and targets to ensure all staff were providing effective care in line with best practice.

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 provider was working within the principles of the MCA, and whether any conditions of authorisations to deprive a person of their liberty were being met. Records showed that mental capacity assessments were carried out for people who needed them. This showed people's rights to make informed choices were protected and supported. Where people had DoLS authorisations in place, these had been kept under review and updated when required Some people's records showed advanced decisions made about their care and treatment. For example, in the event of their sudden collapse. We saw that some DNAR (Do Not Attempt Resuscitation) forms had been signed by the person's GP completing them but had not been signed by the person themselves or their representative to indicate their consent. Whilst the provider is not responsible for the completion of DNAR's, they are accountable for ensuring that any decisions recorded could be lawfully followed for people using the service. We raised this with the registered manager who told us they would review all DNAR with people's GP's to evidence that people's consent was reflected in the

form.

We carried out an observation at lunchtime in two units to understand people's mealtime experiences. We saw people could choose to eat where they wished to. The majority of people chose to sit in the dining areas whilst some people ate their meal in their bedrooms with support. People were offered a choice of two main meals and a range of vegetables were placed in platters on the table. We saw that staff supported people to choose their vegetables and condiments and decide on their portion size. We observed staff encouraged people to eat independently and, where people needed assistance, this was provided carefully and sensitively. People were given encouragement and time so that they could enjoy their food.

People were generally positive about their meals. One person told us, "I would say the food is alright." Another person told us, "The food is very good,". A relative told us they had complained about the poor quality of food last year but felt it had improved considerably since then. We saw that one person had a specific preference for their breakfast and the cook ensured they kept the item in stock for them. We observed that the person responded positively when they were made aware of this and requested the item for breakfast the next day.

The cook told us they received the information they needed about people's dietary requirements. For example, specialised medical diets or specified food consistencies such as soft or pureed diets. They demonstrated they were aware of the importance of meals to maintaining people's health and well-being and gave examples how they had adjusted the menu to reflect people's preferences and wishes. For instance, they had changed the way they ordered food to introduce greater flexibility in menu choice and taken on board people's feedback to make improvements to the quality of food served.

Where people were at risk of poor nutrition or weight loss because of their health condition they had been referred to a dietician and their weight and dietary intake was monitored. We saw that people were given prescribed dietary supplements when required which also helped to ensure they received sufficient amounts to eat. We saw people being offered drinks and snacks at regular intervals throughout the day. One person was distracted during their meal time and we saw that staff sat with them and encourage them to have sufficient to eat and drink to maintain their health.

People's care records we looked at showed that potential risks to their health were regularly assessed. However information in assessments was not always consistent. For instance, one person was assessed in the their care plan summary as being able to drink independently but the person's nutritional risk assessment recorded that they needed support and encouragement to drink. We observed that staff sat with the person to encourage them to drink at lunchtime and demonstrated that they were knowledgeable about the person's current needs. The registered manager explained that they were in the process of updating information as each care plan was reviewed to ensure staff had consistent information to provide people with support to meet their current needs.

We saw that people had access to external health care professionals and services when they needed to and people's health needs were met. One person told us, "I see the doctor regularly, He comes whenever I need to see him. I also go to physio twice a week." A relative told us, "They [staff] always ring us if there are any problems. In the past [name] has had falls due to the fact they walk about very quickly. Staff always call the doctor if [name] is ill." Another relative told us, "[name] has recently seen a doctor who has referred them for specialist treatment. They [staff] referred quickly and sorted it out." This showed that staff had a good understanding of their role in support people to maintain their health and well-being.

Good

Is the service caring?

Our findings

People were happy with the care they received from the service. One person told us, "They [staff] have cared for me extremely well. When I ask for things they are very quick to respond. The staff have been very good to me." Another person told us, "I'm very happy here, it's good." Relatives were also positive about the care their family members received. Comments included, "I think the care home is very good. I visit most weeks and I can't say I have any complaints. [Name] seems well cared for," and "I visit regularly and I am never unhappy about the care."

Staff recognised the importance of people's family and friends to them and made efforts to keep informed of key events and changes that may affect people's relationships. For instance, where a family member was not able to visit so often, staff acknowledged this and provided additional support to the person and their family member in a discreet and sensitive way. This meant that people were supported to maintain relationships which were important to them.

We observed that staff treated people with respect. For example, when staff supported people with their meals and personal care needs. We saw that staff spoke with people before providing care to them, consulting them as to what they wanted to do and if they were ready for support. We also saw staff spoke with people after support was given to check they were happy. We observed shared humour and conversations between people and staff. There was some evidence in people's care plans that staff were in contact with people's relatives to share information on people's care and welfare issues.

People's care records we looked at showed how they wished to be cared for. Their individual choices, preferences and decisions about their care were recorded and used to inform their care. Staff spoken with knew how people liked to be supported and their preferences. For example, we observed one person became distressed after lunch. We saw that staff responded in a discreet and sensitive way, providing reassurance and comfort in line with the person's care plan.

Staff demonstrated that they understood the importance of respecting and promoting people's privacy and dignity and took care when they supported people. During our inspection we observed that staff attended discreetly to people's on-going personal care needs to help ensure they remained clean and comfortable. People's bedrooms were respected as their own space and we saw that staff always knocked and did not enter until asked to do so. All the bedrooms we saw looked comfortable and were personalised to reflect people's individual taste and preference.

People were supported to be as independent as possible. For example, at meal times people were provided with the right level of support which encouraged them to do as much as possible for themselves.

Good

Is the service responsive?

Our findings

People were offered a range of social and recreational activities from staff who had a specific role in the service to provide activities based on people's personal interests. We saw people were able to participate in daily activities such as indoor games, movie nights, gardening and reminiscence. We observed staff supported people to participate in group activities or in one-to-one activities if they preferred. For instance, we saw one person engaged in a word game with a staff member. The person was smiling and demonstrated that they were enjoying the session. Another person was supported to go out for a walk which they liked to do and was given a choice of walking around the garden or the local area. We saw that entertainment had been arranged and a list of future events was available on notice boards, such as musical evenings which people told us they enjoyed.

We spoke with the staff responsible for co-ordinating activities. They told us that an extra activities co-ordinator had recently been recruited to increase people's access to activities. This meant they had more time to spend with people through group and one-to-one activities and were able to develop a program of activities for people. There was little evidence of activities being offered for people once activity co-ordinators had finished working. This meant that people living with dementia were not supported with stimulation or interaction during the afternoon of our inspection. We raised this with the registered manager who told us this would improve once activity co-ordinator rotas had been finalised and an activity programme was in place. For example, activity co-ordinators would work a range of hours across the service to offer activities in a more consistent and structured way.

People's care records contained brief information about people's background, people who were important to them, their life-style preferences and a brief outline of their life history. For example, we saw that one care record stated a person preferred to wear long-sleeves. We saw staff had supported the person to dress in line with their preference. People's needs had been assessed to identify the support they needed, such as their personal care. Care records clearly identified people's preferences, such as food, drinks, likes and dislikes.

We found that staff knew about people and their preferred daily routines. For example, staff were able to describe how they had supported one person living with dementia who could easily become socially isolated. They were able to explain how they had taken time to get to know the person and encouraged them to join in with daily activities. We saw that the person was sitting in the communal areas engaged in a one-to-one activity with a staff member. They looked happy and conversed freely during the activity. Staff were also able to demonstrate that they knew people and their routine well, for instance what time they liked to get up or go to bed, and why this was important to them. A summary of people's interests was displayed on their bedroom doors. People and their relatives told us they had contributed to the content and design of the summary and felt that this supported people with their orientation and sense of individuality.

People had an initial assessment of need and this was used to develop people's care and support plans. These were structured around providing step-by-step guidance for staff to follow to promote consistent

support. For example, one care plan described how the person responded to certain situations and provided guidance for staff on how to reassure the person to reduce their anxiety. We observed that staff followed this guidance in practice. Another care plan stated the person liked to get up early and listen to their radio whilst they were getting ready. Staff who we spoke with confirmed that the person liked the radio on and demonstrated an awareness of the station they liked to listen to. Care plans contained sufficient detail to guide staff when supporting people. However, three care plans that we looked at included conflicting or inconsistent information. We discussed this with the registered manager who told us they were in the process of completing the update on all care plans and this had been a recording error. They told us that the service had a consistent staff team and only used regular agency staff to ensure that staff had the knowledge and information they needed to meet people's current needs. This was confirmed by staff who we spoke with and staff rota schedules that we looked at. The registered manager told us they would ensure information in people's care plans was consistent with their current needs following our inspection.

People and family members had been involved in the review of how their care and support was provided and records showed that changes had been made to people's care plans following reviews if required. For instance, one family had requested that their family member was supported to access the wider community as this was something they liked to do to maintain their emotional well-being. During our inspection visit, we saw this had been incorporated into their care plan and staff supported the person to go out for a walk. This showed that staff had listened and acted on the views of people and/or their family members and were responsive to changes in people's needs.

People and family members knew how to complain. They told us they had been made aware of the registered provider's complaint procedure and were confident to complain if they were unhappy about their care. People and their relatives also told us when they had complained, improvements to care had been made. For example, one relative told us they had complained about the quality of the meals provided. They told us the registered manager had listened to them and taken action to make improvements which both the relative and their family member were happy with. The complaints process was clearly displayed and we saw that complaints had been managed in accordance with the provider's policy. This meant that people could be confident that their concerns would be listened to and acted upon.

Requires Improvement

Is the service well-led?

Our findings

People and staff spoke positively about the registered manager. One person told us, "The [registered] manager is great. They always act on things. They are firm but fair and I am happy to talk to them as they are approachable." Staff told us they felt the standard of people's care had improved over recent months and "The improved environment made it a nicer place to work."

The registered manager had a visible presence with an open door policy, which meant they were accessible to people, staff and visitors. They had a comprehensive understanding as to the care needs of people and we observed throughout the day they had a hands on approach to people and staff. The registered manager was supported by a clinical lead nurse and together they provided a positive role model for staff to follow by promoting and demonstrating best practice in their roles.

There were regular opportunities for staff to provide feedback about people's care. We observed a team meeting which involved the registered manager and staff heads of units. This forum enabled staff to share views and information about people's care and discuss any changes or actions needed for their health and personal care. The activities co-ordinator was able to feedback on people's responses to activities undertaken and the cook was provided with updates about people's dietary needs. Staff were able to share views through their unit heads who also provided feedback following the team meeting. This helped to inform and promote consistency to people's care by ensuring all staff were informed about events and changes within the service.

Staff were supported to share their views through individual supervisions, staff meetings and staff feedback surveys. We looked at the results of the most recent staff survey dated March 2016 which asked staff to feedback on areas of the service such as line manager support, information and communication and working conditions. We saw that feedback was largely positive and results had been collated into statistical information which also included details of any remedial action where appropriate to make improvements to the service. Staff were positive about recent management improvements within the service. One staff member told us, "I have worked in other homes but I decided to stay here as I like it." Another staff member told us that the changes had improved how staff worked together which had resulted in a greater sense of teamwork.

People and their relatives were asked to feedback on the service through resident and relative meetings and forums. We looked at recent minutes of meetings and saw that areas such as activities and food were discussed. Records showed where people or relatives had asked questions, the registered manager had responded with proposed actions or explanations. For example, where people had raised activities, the registered manager had shared proposals for improvements with people. People and relatives were also sent a satisfaction survey by the provider to seek their views about their care and treatment. They were asked to comment on staff, the environment and the quality of care. We viewed a sample of their responses to recent surveys in March 2016. This showed that overall people were happy with their care. Where relatives had raised concerns, such as lack of information or involvement in their family members care, the registered manager told us they had responded to this on an individual basis and made improvements as a result.

The registered manager carried out other regular checks relating to the quality and safety of people's care. This included checks of staff working practices, the environment and care plans and records. The findings from audits were collated into a monthly manager's report which included improvements needed and target dates for remedial action to be completed. A copy of the monthly report was shared with the provider.

We looked recorded checks of people's care plans in May and June 2016. These identified remedial action and target dates. However, in two care plans that we sampled, we saw no evidence that remedial action needed had been implemented or achieved by the target date. Checks of care records were not effective in identifying if action from previous audits had been completed. Checks were also ineffective at identifying that information in people's care plans had not been recorded consistently in line with their current needs. For instance, we saw that one audit identified that a care plan had very little personalised information about the person to reflect their life history, likes and dislikes. We saw that the auditor had given a four week target date for the care plan to be reviewed and updated which had expired. We looked at the person's care plan and found that the care plan had not been reviewed or developed to ensure the plan was person centred and the subsequent audit of the plan had not identified this.

Although the registered manager had reviewed and revised clinical and care policies and procedures, we saw these had not been shared or understood by all staff. For example, we saw that the clinical lead nurse had reviewed the format and content of medicine policies and procedures for the service and these were comprehensive with up to date guidance for staff. However, these had yet to be shared with nursing staff. The clinical lead nurse told us they planned to share with nursing staff following our inspection.

We raised this with the registered manager who told us they had recently reviewed and revised their quality processes to ensure audits were consistently applied. They also told us they had already begun to share information from revised policies and procedures through the team meetings and would ensure staff were supported to understand the changes as part of team meetings and individual supervisions. This helped the provider to ensure people were receiving safe, quality care in a timely way.

We asked local care commissioners of the Leicester City Council for their views about people's care at the service. They told us they had found improvements and received positive feedback from people about their care. They told us that the service needed to demonstrate they were able to sustain the improvements they had made.

The registered manager understood their legal responsibilities within their role. They ensured that the local authority's safeguarding team were notified of incidents that had to be reported and maintained records of these for monitoring purposes. We were also notified of significant events as required to monitor the service.