Four Seasons Homes No 4 Limited

Kingfisher

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection on the 21 October 2014.

Kingfisher House was last inspected 08 September 2014. This was a responsive inspection, by the pharmacy inspector. We issued a warning notice because medication was not being administered safely. The warning notice clearly specified what improvements we required the provider to make and the specific breaches. The warning notice was issued as a direct result of the provider's failure to make the required improvements following a compliance action issued after the inspection in June 2014. Following the Warning Notice the provider took appropriate actions.

Kingfisher House provides accommodation for persons who require nursing or personal care for up to 91 people. On the day of our inspection there were 84 people using the service. The service provides accommodation

Summary of findings

according to need in four separate units. Each unit accommodates people with specific needs including those who require nursing care, residential care or dementia care.

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

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions for themselves and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others.

Staffing levels were not adequate to meet people's individual needs and we have Asked the provider to take action to address tis.

Improvements had been made in the way staff stored, administered and recorded people's medicines which meant they received it safely. We were concerned how long it took to administer people's medicines and were not confident people were getting their medicines at the prescribed time.

Staff had an adequate knowledge of how to keep people safe and individual risks to people's safety wherever possible were reduced. Staff knew who to report concerns to if they had any concerns about a person's care and welfare.

The service adequately supported its staff and had robust recruitment and induction processes for its new staff. All staff received sufficient training for their role and were appropriately supported.

People were supported to eat and drink enough for their needs, although some people were not happy with the quality of the food.

There were robust complaints procedures in place and people were consulted about their care and welfare. Where the service fell short of people's expectations this was addressed.

There was a good programme of social activities which met people's individual interests and hobbies. There was improved engagement with the community and family members were encouraged to join in with things provided at the home.

The service was responsive to people's needs but we found differential levels of care provided on each floor which was indicative of insufficient staffing levels. Some care we judged to be more person centred than others.

The manager was making improvements in the service and was open and transparent. There were systems in place to judge the quality and effectiveness of the service to ensure it was continuously improved.

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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were not enough staff on duty to meet people's needs in a timely, responsive way.

People were protected from harm and abuse as far as possible because staff knew what constituted abuse and knew what actions to take and who to report any concerns to.

People received their medicines safety and there were adequate systems in place for the safe storage, ordering and recording of people's medicines.

Requires Improvement

Is the service effective?
The service was effective

Staff were well supported and there were systems in place to ensure only suitable staff were employed and they had sufficient skills and training to perform their role.

People's capacity was assessed in relation to their health care and welfare and their consent was obtained. People were lawfully protected where they were unable to give consent

People's nutritional needs were monitored and people were supported to eat in sufficient quantities.

People had access to the right health care professionals and their health was monitored and actions taken when there was a change.

Good

Is the service caring?
The service is caring.

The staff acted inclusively and involved families in their relatives care.

Staff developed positive relationships with people and provided person centred care.

Care was provided in a dignified and respectful way which upheld people's rights and promoted people's well-being.

The service worked inclusively with others.

Good

Is the service responsive?
The service was not always responsive.

Requires Improvement

Summary of findings

Care plans reflected people's needs but some were in more depth than others. We found records were not always helpful in telling staff how to provide individualised care but relied more heavily on describing how to manage people's health conditions.

There was a range of activities to suit people's different interests and hobbies which promoted people's well-being.

There was an effective complaints procedure in place and people were consulted about their care so any shortcomings could be addressed.

Is the service well-led?

Good

The service was well led

There was strong leadership and clear lines of responsibility and accountability.

There were systems in place to measure the effectiveness of the service provided which enabled to manager to take corrective actions.

The service learnt from events affecting the wellbeing and, or safety of people using the service and audits identified factors which posed a risk to people. Risks whenever possible were managed.

Kingfisher

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on two separate dates 21 October 2014 and the 29 October 2014.

The inspection was carried out by a lead inspector, a bank inspector, a specialist advisor whose expertise was in pressure care and nutrition, and a pharmacy inspector. We also had an Expert-by-Experience who is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert-by-Experience had experience in supporting older people.

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 also reviewed the information we held on our system such as the number of complaints and events affecting the wellbeing and, or safety of people using the service.

During the inspection we spoke with 13 people who used the service and five relatives. We spoke with seven staff, and looked at eight people's records to see if they told staff how to meet people's needs. We observed care to see if staff understood people's needs. We reviewed some records relating to the running of the business in relation to staffing and health and safety issues. We looked at quality audits to see how the manager measured the quality of the service it provided.

Requires Improvement

Is the service safe?

Our findings

On the 6 September 2014 we issued a warning notice following a continued breach with medicines. This was followed up by the pharmacy inspector on the 26 October 2014 and we found they had made the improvements they had been asked to make.

There were safe systems in place for the administration and storage of medicines. We found prescribed medicines were available for people which meant staff were ordering medicines on time for people to ensure they did not run out of medicines. There was a written record of medicines administered to people to show they had received their prescribed medicines. The manager had asked prescribers to review some people's medicines and there were records about this. This ensured that people's medical needs were kept under review and medicines were still appropriate to people's needs.

One person told us that staff did not know what medicines they should be taking and sometimes staff had made mistakes because of this. We fed this back to the manager at the time of our inspection for them to take immediate actions. On both days of our inspection we saw that the morning medicine round was excessively lengthy so some medicines were not administered until significantly later than scheduled. This meant people did not get their medicines at the prescribed time. The manager gave us assurances that they were taking action to resolve the matter.

We observed the nurse giving out medicines on two separate occasions and saw that medicines were administered correctly and in accordance with the provider's medication policy. Medicines were recorded following administration so there was an accurate record of what people took. One person refused their medicines and their wishes were respected and their refusal was clearly recorded. This meant the medicines were given safely and according to people's expressed consent and wishes.

Staffing levels were not appropriate to meet the needs of people using the service. One person told us "The girls are rushed off their feet and there are a lot of agency nurses" The manager told us there were several staffing vacancies, particularly nursing vacancies. This meant they relied on agency staff who were not as familiar with the needs of people using the service. The manager had tried to recruit staff and recently held open days to try and attract staff with some success. They were waiting to complete their recruitment processes. The manager said two nurses were on leave this week which left a skills gap. The agency nurse we met had only been at the home two days and was not familiar with people's needs. We saw the impact of this as it took them a significant period of time to administer people's medication starting at breakfast time and not finishing until lunch time.

Some people were able to summons staff assistance and this was provided quickly whilst other people unable to use their call bell had a delay in having their needs met. One person was overheard crying out for help and unable to use their call bell. Staff were busy attending to other people so were unaware. They were calling out for fifteen minutes. We observed them getting more distressed. Staff did eventually come and assist this person but did not acknowledge their distress. One other person with restricted mobility was seated well out of reach of their call button, which meant they could not summon help quickly. Before the inspection we received concerns from relatives about the call bell response times. The manager told us they did not monitor call bell response times and the system did not produce a print out so we could not see if call bells were always answered promptly.

Visiting professionals told us that a good service was provided to people using the service but said that sometimes they found it hard to find staff either to handover information from their visit or to find out how the person had been before they visited. This is indicative of staffing levels being insufficient at times.

People said staff were kind but did not have time to stop and chat. Several relatives told us there were not always enough staff and personal care was often rushed and call bells were not answered in a timely way. Staff told us there were not always enough staff and they were very busy and found it hard to meet people's needs in a timely way. We saw that staff worked hard throughout the morning and did not finish meeting people's personal care needs until lunch time and then they assisted people with lunch. This meant that once people were assisted up they received very little interaction or stimulation from staff other than around their personal care. We found as we were walking round it

Requires Improvement

Is the service safe?

was not possible to find staff and in the communal areas staff were not always visible which meant people might be at increased risk of falls or not getting the help they needed.

There was a formula used by the provider to calculate the number of care hours they required based on people's dependency levels. This was ineffective in determining the right levels of staffing.

We found that the arrangements for staffing did not meet the needs of the people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities)Regulations**.**

People's safety was promoted within the service. One person said, "I feel very safe here" and another said, "There's a nurse here all day and all night." This person kept their door open all day but said, "It is closed at night, probably more for privacy than safety."

Staff had received training on protecting people from abuse and the manager responded appropriately to any allegation of abuse. Staff spoken with were aware of what actions they should take to protect people. The manager told us staff would be attending more detailed training provided by the Local Authority but did not provide us with dates.

We saw that staff kept appropriate records and body maps for people indicated any bruises or injuries, which included photographs so there was a clear audit trail from identification to actions taken by staff. There were policies and procedures in place to tell staff how they should protect people from harm or abuse people. Staff were aware of how to report concerns and who they could contact if they had a concern about anyone.

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We spoke with one person who told us about their experiences of living in one unit. They told us people came into their bedroom uninvited which made them feel unsafe. Their relatives said they had also witnessed this and said that they had been concerned for their family member. The person was moved to another unit and said they felt safer. However we noted that this person might not have been suitable for the unit they were first admitted to. We found the assessment process did not take into account the person's primary need and did not consider any compatibility issues. This meant the home had not initially been able to meet these people's needs which had attributed to them feeling unsafe.

Risk assessments had been completed for areas such as; mental health, medicines risk, skin integrity, transfer actions, and falls but not all risk assessments were up to date or took account of recent changes to people's needs. For example The GP was informed of residents' weight loss, but this was not always recorded in the evaluation or review. Most assessments recorded what actions were in place to reduce the risk. Some people had bedrails to prevent people falling from bed. People's consent had been sought for these to be in place and the beds rails were regularly checked to make sure they were safe to use. We saw that risks to people's safety and anything affecting people's wellbeing had been assessed and actions taken to ensure people's specific needs could be met. This was demonstrated by records and the staff we spoke with who were aware of people's needs and the need to keep people safe.

Good

Is the service effective?

Our findings

People received effective care, because the staff had the knowledge and skills they needed to carry out their roles and responsibilities.

The service had effective recruitment processes in place and new staff were supported through a detailed induction. This includes being supported by more experienced staff on shift until they were confident to work on their own and they completed a three month probationary period. In this time they were required to work through a structured induction workbook which gave them a basic introduction into care.

We saw recruitment files and these showed an adequate process, although one record did not show all the required documentation. This was held at head office, but there should be evidence of this on file.

Staff told us they received the necessary training required for their roles and this was kept up to date. This was demonstrated by a datex system which recorded all staff training and flagged up in a different colour when training was almost due or overdue. We saw from the statistics that most training was over 90 % compliant. We saw examples of training recently undertaken and, or planned. The manager said lead roles for some staff were being developed. Staff champions would receive additional training and be a resource for other staff. It also meant that they could promote best practice throughout the service and improve standards of care.

Staff received supervision of their practice through one to one supervision, annual appraisal observation of their practice and handover meetings so they could share their ideas and observations. Staff told us they felt well supported.

Consent to care and treatment was sought in line with legislation and guidance. We observed staff offering people choices in relation to their care and welfare. People's care plans included a section called 'rights, consent, capacity' which recorded people's ability to make decisions about day to day care. If they were unable to make a specific, more complex decision this was recorded and we saw what they needed help with. We saw who had been involved in making decisions for people in their best interest when they had been unable to such as family members with power of attorney and health and social care professionals.

The manager understood the Mental Capacity Act, (MCA) 2005 and Deprivation of Liberties safeguards, (DoLS.) They had made DoLS applications as required. All staff had received basic training in MCA and DoLS through e-learning. The manager said some more advanced training was planned for staff. We spoke with staff and they understood how to support people and report concerns where people were unable to make best interest decisions.

We looked at a sample of care plans and saw there was a best interest checklist. Where people lacked capacity to give consent for example for the administration of the flu vaccination, family members had been consulted and documents signed and dated by them and signed by senior care assistants. We were not always able to see if a health care professional had been consulted in relation to the flu jab and it is not enough to ask family to consent unless they had power of attorney. Mental capacity assessments were in place which assessed people's ability to make decisions and what help they might need to ensure people's rights were upheld.

People were supported to maintain good health and have access to healthcare services. One person said, "The staff are marvellous, I am consulted about my needs and my health has improved." We saw that they had put on a healthy amount of weight since admission and were supported by a range of other health care professionals. Another person said, "I have been here a long time, I am keeping well, I am well looked after." We looked at people's care plans and saw detailed recordings of any visits from health care professionals, what had been discussed and what actions staff had been asked to take. Care plans had been updated as a result of these visits and the information was also recorded on the staff handover sheet and the communication book. We also saw evidence of how the nurses in the home regularly reviewed people's health and where there were concerns monitored their urine, blood pressure and other vital statistics to detect illness or monitor health conditions.

We spoke with a physiotherapist and an occupational therapist. They told us staff made referrals for their services in a timely way which ensured people's needs were responded to appropriately. The manager said they used a number of different GP surgeries so people had the choice and could retain their own GP if in the area.

People's prescribed medicines were regularly reviewed and people monitored for unwanted side effects caused by the

Good

Is the service effective?

long term use of medicines. Medicines required when necessary such as for water infection were prescribed and written up in people's care plan so it was clear what people were taking and why. This meant the service was effective in meeting people's health care needs.

People were supported to eat and drink in sufficient quantities for their needs. People were offered appropriate choices and support to eat their meals. One person said "Some food is OK", "All the food is OK – I eat it all don't I", "The food could be better" and "I had a nice salad – it was lovely." People had a choice of where they ate their meal but people were encouraged to eat in the main dining rooms to help alleviate social isolation. Staff were sensitive to people's individual needs and if someone preferred to stay in their room this was recorded in their care plan. People were given a choice of two menu options or an alternative if this was not favourable. If people had difficulty choosing, staff prompted them by showing different plates of food to help them decide. The food we saw was well presented and served hot. People who needed help with their meal were assisted appropriately. Staff provided support in a communicative and sensitive way. Care staff were familiar with people's dietary needs and knew who required encouragement.

There were systems in place to identify people at risk from preventable weight loss. The nurses spoken with were aware of how to calculate a person's weight if they were unable to be weighed using scales. This was important as it enabled staff to establish a weight baseline and monitor people's weight. The manager had identified a further five staff to receive training in using the malnutrition universal screening tool.

One person told us they had put on planned weight since being at the service after a long period in hospital. They said their health care needs were met and their weight was carefully monitored. People's nutritional needs assessments were completed on admission to ensure people's weights could be immediately monitored. Staff we spoke with knew what actions to take where there were concerns about unplanned weight loss. The expected outcome recorded in the care plan was for individuals to have a well-balanced diet to avoid weight gain or loss. Food preferences and foods to avoid were noted.

People's dietary needs were recorded in their individual plans. There was a white board in the kitchen with people's names and dietary requirements on. Staff were familiar with people preferences and offered people choices. This meant staff knew what people's needs were and responded accordingly.

Meal times were at staggered times on the different units. Lunch was served efficiently on two of the three units we observed but there did not appear to be enough staff to support meal time on the nursing floor. One relative told us that food was sometimes cold when they visited their family member Staff told us that four people required assistance with their meals and ten people required support to eat. There were five staff serving people their meals. The main dining room was well utilised and people in the dining room were served first. Then staff served up food for people in their rooms and lunch then took well over an hour an half. We did not observe food going cold on the day of inspection but shared our concerns with the provider.

Good

Is the service caring?

Our findings

Positive caring relationships were developed with people using the service. Everyone we spoke with were complimentary about the permanent members of staff and said they were kind and caring. One person said "I like them – they're all nice girls." Another said "They are polite all day and every day", and another said "The girls pop in to tell me about their families and their children."

Through our observation we saw that staff were kind and caring. We observed lunch in three of the four units. We saw staff assisting people in an unhurried way. We observed a person who was nursed in bed being assisted by care staff. They assisted the person with their meal at the person's pace. The person had very limited communication but the care staff continued to chat with them throughout in a friendly, caring way. We saw staff offering people positive encouragement and praise. which meant that staff were engaging with people appropriately and enhanced their sense of well-being.

We spoke with a number of relatives. One relative told us they were very happy with the care provided. They said they were kept informed about their family members care and found staff very supportive and kind. They said they welcome the whole family and provide them with emotional support.

Throughout the day we saw that staff maintained people's privacy and dignity. For example when a person was being visited by a health care professional a screen was pulled round to give them some privacy and there were other health care professionals visiting people in their rooms and they shut their doors so to retain the person's confidentiality and privacy.

We asked two people if they were able to decide when they get up. One person said "When staff ask if I am ready for help with washing I could say 'come back in an hour', for instance, and that's OK with them." Another person said they got up when staff were ready to assist them and they did not mind this. People's choices and preferences were recorded in people's care plans. We observed staff offering people appropriate choice of activity, food and drink. We noted that people were well dressed and were warm as the units were appropriately heated and some people had additional clothing, and, or blankets across their knees with also helped to preserve their dignity.

People were encouraged to express their views and be actively involved in making decisions about their care and welfare. People said they were involved in their care and staff consulted them about their needs. This was recorded in people's care plans. When people's needs had been reviewed, they had been included in discussion along with family members where appropriate. We saw that when consultation had taken place with a health care professional families had been informed about the outcome. Important decision such as whether a person wanted to be resuscitated had been recorded and discussions held with professional members and families.

One person's records we looked at showed they had limited capacity due to complex medical condition and frailty therefore family members had been consulted on any complex decisions. People's decisions were known which demonstrated that people lived their lives the way they wanted to and they were supported with decision making.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. We carried out observations on each unit to make a judgement about the care people received. On the whole we found the care to be very good. However we were concerned that people who required nursing care on both units sat for long periods without staff supervision and interaction. Some people told us they felt isolated and one person told us they would like to go out but couldn't without staff. Staffing levels did not appear appropriate to meet everyone's needs and we saw different levels of interaction with people from staff. Most were good but we saw one poor interaction which involved poor communication with the person which we fed back to the manager at the time. We also found differences in how the care plans were written. The care plans on the dementia care unit, (residential) were individualised and started off with 'What a good day looked like for a person,' and helped staff provide personalised care. Through our observations on the dementia unit, (residential) we saw people were regularly engaged with staff and there was lots of chatter and positive body language.

When reviewing information for this service we have been notified of a couple of relatives who have been unsatisfied of the level of care given to their family member where they did not feel their needs were adequately met.

People's needs were assessed before admission to the home and this was thorough. However concerns had been expressed with us about whether the unit's people moved to were always the most appropriate for the person's needs. We looked at care plans and found them very comprehensive but inconsistent in terms of style with nursing records focussing much more on people's nursing needs rather than more social aspects of their care. Whereas the care plans on the dementia unit were much more personalised. These identified how staff should provide responsive, individualised care as people's likes, dislikes and personal preferences were recorded. There was a document called. 'All about me' which told us about the person's history and family life. Not all of these were completed which meant staff did not know much about people's background which would assist them in understanding people's needs and behaviours particularly where people were living with dementia.

Care plans were kept under review and showed how changes to people's need had been addressed. We saw regular input from health care professionals and people's medication had been reviewed.

Care plans documented personal details of care giving such as if people minded a male of female carer so care could be delivered according to people's expressed wishes. Care plans gave details about people's medication, how they wished for them to be administered, by whom and this had been reviewed to take into account changes in need. Care plans also stated whether people preferred their own or the company of others particularly in relation to lunch time.

We saw that people's needs in terms of how they liked to spend their time were recorded. For example: garden walks, reminiscences, music, reading, word games and favourite pass times. The activities coordinator was aware of this and tried to incorporate people's individual preferences within their activity schedule. Care plans referred to significant people in the person's life. We saw that staff supported people in maintaining these relationships and links with their past and their community.

During our inspection we saw the activities that were being provided were well attended and enjoyed by those participating. People were encouraged to join in. There was an activity programme for the residential unit and one for the dementia unit both providing nine sessions a week on weekdays. We observed one activity session led by the activities co-ordinator. There were twelve people present and this had risen from five in total only a few weeks ago. The co-ordinator was assisted by two other staff. The session, based on a word game, was conducted in a friendly manner. We saw that it was stimulating, very interactive and was dependent upon responses from people participating. There was sustained interest and people were engaged for more than an hour.

Family members were encouraged to join in at the home and take part in meetings and activities. A monthly newsletter was emailed to families and displayed around the service. This informed relatives of any changes to the service and forthcoming events so they could choose whether to get involved or not. We asked people about activities and some people said they chose not to join in. One person said, "There are activities for the ladies but not much for the men folk." We told the manager about this so they could address this. There were activities provided from

Requires Improvement

Is the service responsive?

members of the community such as 'Pets as Therapy' (PAT) scheme. The local community raised money and donated raffle items to raise funds for the service. A local retailer regularly donated flowers which were used for flower arranging sessions.

Complaints and concerns were recorded and we could see what actions the manager had taken to address the concerns in a timely way. This meant they had an effective complaints procedure. The manager reported concerns to the appropriate authorities where required and completed detailed investigations when asked to by the local authority to establish the facts and where necessary required improvements.

Concerns raised by family members had been addressed with the individuals to see if a resolution could be found which meant the manager was responsive to people's concerns. Family members spoken with were aware of how to complain and to whom. We spoke with some people who told us they had no concerns about the care they received. One person had not been happy with how their complaint had been responded to. One person raised concerns which we passed onto the manager to deal with. The manager told us they spoke with this person everyday so were aware of some of the concerns.

During our inspection we received concerns about the food. The manager was already aware that this was an area which required improvement and told us they had identified this through resident/relative meetings. They had set up a quality food group who were responsible for meeting to collate concerns and look at menus to see how improvements could be introduced. This group was open to people using the service, relatives and staff. This was work in progress as only one meeting had taken place but meant the manager was proactive in listening to people's concerns and people were actively involved in planning the menu.

Good

Is the service well-led?

Our findings

The manager was developing a positive culture that was person-centred and inclusive. The service has seen a lot of changes to its senior management team. There have also been four registered managers in the last three years. This has meant that improvements identified at previous inspections had not always been sustained. The new manager had implemented some positive changes and we identified clear improvements. Staff spoken with told us that they were happy and that things had improved they felt well supported.

The manager demonstrated good management and leadership. Staff had clear lines of accountability and duties and audits were shared out amongst Heads of Department and trained nurses. Heads of Departments were responsible for their team of staff in terms of supervision. This meant the staff structure was well defined and duties delegated effectively. There was a new area manager in post and the manager said they felt well supported by them. The manager told us a new area manager had recently replaced the interim manager and had carried out an initial audit of the premises. The manager said they were supported by other managers within the organisation who met monthly to support each other and kept up to date with any changes/best practice. The manager told us they had a lot to do in managing a large service and said they delegated as much as possible but said this was difficult when they had staffing vacancies and staff retention issues.

One relative spoken with said they had never seen the manager. Another said "I've seen the manager walking about but she never comes in to see me." We discussed the above with the manager and they told us they spent time going round the service each day but it was a large service so they might not be visible to everyone. They said their office door was always open and the office was situated in the front of the service so they were accessible.

We asked the manager how they ensured they provided a good quality service. They told us people using the service were consulted through 'resident and relative' meetings which people told us they were aware of. There was a newsletter and relatives told us they were consulted about changes to their family members needs which gave them confidence in the service. This was evidenced in people's care plans. One member of staff told us they put effort into getting families involved and felt this was strength. We also saw a much greater participation with the local community such as retail providers sending flowers to the service and other goods being donated free of charge

Annual satisfaction surveys were given out to relatives and people using the service and were compiled centrally. The manager did not have the results of the most recent audit completed this year which meant we could not see what issues had been identified. The last audit was completed in June 2013 and we saw what actions the service had taken to address any areas of concern. The manager said feedback was obtained from visiting professionals as part of this audit. A lot of people were not able to complete a survey or participate in resident/relative meetings. The manager told they used direct observations of care on a daily basis and through more formal monthly audits which had lapsed whilst there was no senior management support. More detailed audits were carried out on the dementia care unit to assess that staff were providing individualised care and promoting people's well-being.

The manager told us they had close working relationships with other health care and social care agencies to ensure the service provided met people's needs.

Audits showed us that risks to people's health and safety were identified and closely monitored to see if the service was taking appropriate actions to reduce risks. For example individual records included an assessment of risk for areas of daily living and specific health care needs such as the risk of developing pressure ulcers. The assessment included details of actions staff should take to minimize the risk. This was evaluated regularly to ensure the actions were reducing the level of risk. In addition the manager completed service audits looking at the number of reported incidents, prevalence of falls, pressure ulcers or anything else affecting the wellbeing and or safety of people. Through their analysis they identified if preventative measures were appropriate and if the staff were promoting people's needs. Where concerns were identified the manager was able to demonstrate actions they had taken to improve the service.

Records and audits showed us the service was well managed with clear lines of accountability and actions taken to reduce risk where identified. The manager showed us a remedial action plan which was a tool which looked at all aspects of the service delivery and identified where

Good

Is the service well-led?

improvements were required. The manager was expected to keep this up to date and as it was on line; their manager could look at it to see what outstanding actions there were. This helped them to assess the manager's performance.

The biggest concern we identified was around staffing levels. However we saw the provider was trying to address this. In addition to ongoing recruitment a new audit tool was being piloted to more accurately determine how many staff were required to meet people's needs.

We saw that staff received regular supervision of their practice and annual appraisals of their performance. Staff meetings were held for staff to receive updates and handovers usually occurred between each shift unless all the staff were working on a long day. The manager said the nurses were directly observed to ensure their practices were up to date and they had received training on key aspects of their role. However the manager said there was no system following staff induction to observe care staff practice to ensure it was appropriate for the needs of people using the service. This could be implemented so the manager had oversight of how care staff were performing in their role.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There was not enough staff to meet the assessed needs of the people using the service. Regulation 9.