J Lysaght

Warren Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This unannounced inspection of Warren Park Nursing Home care home took place on 9 February 2016.

Situated in a residential area of Blundellsands, Liverpool, the home is registered to provide nursing care for up to 40 people with general nursing needs. The home has four floors with lift access to three flours and stair access to the administrative office on the fourth floor. There are large accessible gardens to the rear of the building and car parking to the front. The home is accessible to people with limited mobility and wheelchair users.

There were 39 people living at the home when we carried out the inspection.

A registered manager was 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.

People said they felt safe living at the home and were supported in a safe way by staff. Staff understood what abuse was and the action they should take to ensure actual or potential abuse was reported. Staff understood and adhered to the principles of the Mental Capacity Act (2005).

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. People and their families told us there was sufficient numbers of staff on duty at all times.

Our review of a selection of care records informed us that a range of risk assessments had been undertaken depending on people's individual needs. These included a falls risk assessment, lifting and handling assessment, nutritional and a skin integrity assessment. Care plans had been developed based on the outcome of risk assessments and they provided good detailed guidance for staff on how to support each person thus minimising the risks.

People told us they received their medication at a time when they needed it. We found that the medicines were not always stored in a safe way. You can see what action we told the provider to take at the back of the full version of this report.

The building was clean, well-lit and clutter free. Measures were in place to monitor the safety of the environment.

Families we spoke with told us the manager and staff communicated well and kept them informed of any changes to their relative's health care needs. People said their individual needs and preferences were respected by staff. They were supported to maintain optimum health and could access a range of external health care professionals when they needed to.

People spoke highly of the meals and the general meal time experience. They told us the food was very good and they got plenty to eat and drink.

People and families described management and staff as caring, considerate and respectful. Staff had a good understanding of people's needs and their preferred routines. We observed positive and warm engagement between people living there and staff throughout the inspection.

Although staff said there was a need for formal supervision, they told us they were well supported on a day-to-day basis and through the induction and appraisal processes. They said they were up-to-date with the training they were required by the organisation to undertake for the job.

The culture within the service was open and transparent. Staff, people living there and families said the registered manager was approachable and inclusive. They said they felt listened to and involved in the running of the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it. Opportunities were in place to address lessons learnt from the outcome of incidents, complaints and other investigations.

A procedure was established for managing complaints and people living there and their families were aware of what to do should they have a concern or complaint. We found that a complaint last year had been managed in accordance with the complaints procedure.

Audits or checks to monitor the quality of care provided were in place and these were used to identify developments for the service. Processes were in place for people living at the home and their families to provide feedback on the service. We were provided with examples of improvements made to the service as a result of feedback.

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.

People got their medicines at a time when they needed them but medicines were not stored securely and safely at all times.

Appropriate risk assessments had been undertaken depending on each person's individual needs.

Staff understood what abuse meant and knew what action to take if they thought someone was being abused.

Measures were in place to regularly check the safety of the environment and equipment.

There were enough staff on duty at all times. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

People told us they liked the food and got plenty to eat and drink.

People had access to external health care professionals and staff arranged appointments readily when people needed them.

Staff said they were well supported through induction, supervision, appraisal and on-going training.

Is the service caring?

Good

The service was caring.

People living at the home and visiting families consistently

expressed that were happy with the care provided at the home. We observed positive engagement between people and staff.

Staff treated people with respect, privacy and dignity. They had a good understanding of people's needs and preferences.

Is the service responsive?

Good

The service was responsive.

People's care plans were regularly reviewed and reflected their current needs. People said the care was individualised and care requests were responded to in a timely way.

A varied programme of recreational activities was available for people living at the home to participate in.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

Is the service well-led?

Good

The service was well led.

Staff spoke positively about the open and transparent culture within the home. Staff, people living there and families said they felt listened to, included and involved in the running of the home.

Staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Processes for routinely monitoring the quality of the service were established at the home.

Warren Park Nursing Home

Detailed findings

Background to this inspection

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

The inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A 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. We also looked at the notifications and other intelligence the Care Quality Commission had received about the home. We contacted the commissioners of the service to see if they had any updates about the home.

During the inspection we spent time with four people who were living at the home and three family members who were visiting their relatives at the time of our inspection. We also spoke with the registered manager, the two directors, two registered nurses and two care staff. In addition, we spoke with two housekeeping staff and the chef.

We looked at the care records for four people living at the home, four staff personnel files and records relevant to the quality monitoring of the service. We looked around the home, including people's bedrooms, the kitchen, bathrooms and the lounge areas.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt secure living at the home and were supported in a safe way by the staff. A person said, "I am very happy with what staff do for me and, yes, I feel very safe being here." Families too said they believed the building was secure. A family member said, "She can walk about a bit and be safe because the floor is not slippy."

People living at the home told us they received their medication at a time when they needed it. A family member said to us, "While I have been here my mum has received her medication and the nurse was very patient with her. As far as I know they give the medication out at the same time every day."

We spent time with a registered nurse who explained and showed us how medicines were managed. The medication room was clean and tidy and the medicine policy was available for nurses to access. The policy was reviewed in July 2014 and was in accordance with national guidance on managing medicines in care homes. We did note that the policy made reference to the previous regulations and we highlighted this to the registered manager at the time of the inspection. The nurses we spoke with were aware of the policy. There was a procedure for ordering, receiving and destroying medication. When not in use, the medication trolleys were securely and safely stored. There was no indication of over ordering or excess stock.

Nurses had access to a nationally recognised medication reference book (referred to as the British National Formulary or BNF). We noted the BNF was not the most recent version and highlighted this to the nurse at the time. We checked the controlled drugs, how they were stored and the registers; all was accurate and up-to-date. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Legislation. Medicine that required refrigeration was stored correctly and daily fridge temperatures were recorded and signed for. Topical medicines (creams) were stored safely.

The medication administration records we looked at had been completed appropriately. They included a recent photograph of the person, any known allergies and specific instructions about administering the medicine. Running balances of medicines were being recorded, as was information about medication given when needed (often referred to as PRN medication) and reasons for refusal.

Medication errors were being recorded, reported and action taken to reduce risk and minimise the error occurring again. Staff told us they had received medication training and advised us that medication competency checks had recently been introduced.

We observed medicines being given out at breakfast time. Although the medicine trolleys were locked when the nurse went into a bedroom to give the person their medicine, we noted that the blister packs were left on top of the trolley. This was unsafe practice as the nurses were not always able to see the trolley from the bedroom. We observed that the medicine trolley on the ground floor was left unattended with the keys in the lock for at least 10 minutes. These meant medicines were not stored securely and safely at all times.

This was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The staff we spoke with could clearly describe how they would recognise abuse and the action they would take to ensure actual or potential was reported. The home had an adult safeguarding policy in place. Staff confirmed they had received adult safeguarding training and records we looked at confirmed this. A member of staff said to us, "If a resident was being abused I would inform the manager straight away and tell them what I thought was happening."

People living at the home said staff were always available and they did not have to wait long if they needed something. Families too were satisfied with the staffing levels. A family member said to us, "Each time I come to visit there always seems to be plenty of staff – as soon as people ask for something one of the staff is over to help." Another told us, "It's very well-staffed and they [staff] are on the ball."

We asked staff their view of the staffing levels. They said there was usually enough staff on duty to meet people's needs in a timely way. A member of staff said, "Staffing levels at the moment are really good. Today we have seven carers in, two nurses, the manager and other staff." Another member of staff said, "Generally the staffing levels are good. It's a great help having two nurses because the medication takes a while."

Throughout the inspection we observed that people's personal care and support needs were met in a timely way by staff. Staff were regularly in-and-out of the shared areas supporting people and/or checking on their safety. There was a calm and unhurried atmosphere and people were not rushed when being supported by staff.

We looked at the personnel records for four members of staff recruited in the last year. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff. A system was in place to check the registration status of the nurses every three months to ensure their registration with the Nursing and Midwifery Council was current.

The care records we looked at showed that a range of risk assessments had been completed and were regularly reviewed depending on people's individual needs. These included a falls risk assessment, lifting and handling assessment, nutritional and a skin integrity assessment. Care plans had been developed based on the outcome of risk assessments and they provided good detailed guidance for staff on how to support each person thus minimising the risks.

We observed from the care records that a person who recently moved to the home had had a number of falls as a result of unpredictable seizure activity. The home had responded appropriately by drawing up a detailed care plan regarding the risks associated with the management of the seizures and related falls. The care plan was hand written and hard to read so the registered manager said they would have it typed and also a copy placed in the person's bedroom for staff to access.

For people who needed support with moving, a moving and handling assessment was located in their bedroom, along with a detailed description of any equipment needed and how to use it. This meant staff had readily available instructions in place to ensure each person was moved safely.

A process was in place for recording, monitoring and analysing incidents. A structured and detailed monthly analysis of incidents (mainly falls) was undertaken by the registered manager and. Themes were explored, such as where the fall happened and comparisons were made to see if an increase in falls related to a change in dependency needs. We asked staff how feedback was shared with them about the outcome of

investigations into incidents. They said this was usually through handovers. A member of staff said, "It is mainly informal feedback. If it is about drug errors then each of the nurses gets a letter sent to them."

We had a look around the home including some bedrooms and observed that the environment was well maintained and clutter free. Equipment was clean and in good working order. A call-bell system was in place in the bedrooms and it was checked regularly. Systems were established for checking the safety of the water, fire systems, emergency lighting and equipment. Service level agreements were established for moving equipment, heating, lighting, electrical and gas checks. The records for the checking and servicing of equipment, including portable electrical appliances were up-to-date. A personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the home so that they could be evacuated safely and efficiently in the event of an emergency. These were located in each person's bedroom and in the foyer.

The environment was clean with no unpleasant odours. A person living at the home said, "You see cleaners around every day even at the weekends. The home is always very clean and our bedrooms get cleaned every day." A member of the housekeeping team told us, "We get a cleaning schedule every week and the housekeeper checks all areas to make sure the cleaning has been finished." A member of staff said to us, "We work very hard here to keep the home as clean as possible; we have a good team here." Liverpool Community Health conducted an infection control audit in 2015 and the home received a compliant score.

Good

Is the service effective?

Our findings

We asked people their views about the food and received positive feedback. A person said, "I do like the food here and you get a nice choice. I have been told it is all homemade." Another told us, "The meals are pretty good and you get lots of tea, coffee and biscuits."

Families we spoke with were also pleased with the meals and access to regular drinks. A family member said, "The food is very nice. It is all homemade. They try different things. The shortbread biscuits with lemon curd were lovely."

We had lunch in the dining room with some of the people who lived at the home. There was a calm atmosphere and sufficient staff were present to support people. Where possible people were encouraged to eat and drink independently. Some people opted to eat their meal in their bedroom. Others needed full support with their meal and staff provided this level of support in an unhurried way. A choice of food and various drinks were offered. People who were on soft or blended diet were provided with a meal that looked appetising. There was very little food wasted, which is often an indicator that people enjoyed the meal. There was a coloured tray system in place to indicate the level of support each person needed with their meal.

We asked the chef how they were kept up-to-date with people's dietary and nutritional needs. They said, "After a while you get to know what residents like; I know who is diabetic, who has an allergy to anything and those on soft diets. If anything changes I am the first to know."

The people we spoke with all told us they had access to health care services when they needed it. This included visits from or to the GP, chiropodist or dentist. A person told us, "The staff call the doctor when I need to see him." What people were telling us was confirmed by the information in the care records. We could see from the records we looked at that local health care professionals were contacted in a timely way when needed.

The care records showed that nursing staff carried out regular health checks for people, including blood sugar monitoring for people with diabetes, temperature checks and blood pressure monitoring. One of the nurses told us that these checks were routinely carried out to check for potential health concerns. People's weight was monitored on a regular basis and we could see that any significant weight changes were addressed, such as a referral to a dietician.

Throughout the day we observed and heard staff encouraging and prompting people with decision making regarding their care needs in a positive way. Before providing support, we heard staff explaining what they were going to do in a way the person understood. The care plans were recorded in a way that encouraged staff to seek consent from people before supporting them with daily activities, such as personal care. For example, we saw recorded in a care plan, "Give xxx a choice of clothing." We also observed that people or their representative had signed to say they consented to their photograph being taken. A person who had capacity had signed an agreement indicating they supported the use of bedrails to prevent them falling from

bed when asleep.

Although the home was for people with general nursing needs, the registered manager identified at least 24 people who would likely have limited mental capacity to make certain significant or complex decisions. Therefore, we looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The 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 make 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).

Deprivation of Liberty Safeguards (DoLS) authorisation requests had been submitted to the Local Authority for some of the people living at the home who needed this level of safeguarding. We looked at some of the DoLS applications for authorisation. They showed staff understood the principles of the MCA and DoLS. The registered manager advised us that a registered mental health nurse had been appointed. This was identified as a need due to people living at the home over time developing needs associated with memory that impacted on their ability to make informed decisions. The registered manager and staff told us the appointment of the registered mental health nurse had supported the team greatly in terms of understanding mental health issues and taking the lead with MCA matters, and the completion of DoLS applications. Through conversation with us, staff demonstrated a good awareness of the principles of the MCA. Training records showed that senior staff had completed training in DoLS.

We did not see that any decision-specific mental capacity assessments had been undertaken for the people who had had a DoLS authorisation request in progress. We discussed the importance of these with the registered manager as they are the starting point to identify that the person lacks capacity. The registered manager confirmed the DoLS process had been discussed with families and they said they would ensure mental capacity assessments were completed in the future to show that complex decision making was being undertaken in accordance with the MCA.

Staff told us that people's wishes regarding their end-of-life care were known, including their decisions about resuscitation. We could see that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) plans were in place for some people. These were in accordance with the MCA and had been coordinated by the person's GP. We noted that one DNACPR form indicated that the GP had not discussed the matter with the person's family. We mentioned this to the registered manager who agreed to follow this up.

We spoke with staff who had been through an induction within the last 12 months. They said the induction was thorough and included completing an induction handbook and shadowing a more established member of staff until they felt confident enough to work independently. A member of staff said, "The staff induction covers safeguarding, emergency procedures and shadowing." One of the directors told us, "Any new staff will start on the care certificate standards and existing staff will complete any areas that need to be done to get the qualification."

All the staff we spoke with all told us they had received an annual appraisal. A monitoring process was in place for appraisal and it confirmed that annual staff appraisals had taken place. There were mixed views amongst staff in relation to supervision. Some staff said the level of supervision was good and they felt well supported on a daily basis, albeit in an informal way. They said nurses and/or managers were always available to respond to queries or provide support. A member of staff said, "I do feel I am supervised. We

work closely and discuss things." Other staff members said they would like more regular and formal supervision. The registered manager and one of the directors acknowledged that supervision was up-to-date for the night staff but also acknowledged that a formal approach to supervision was something they needed to look into and they agreed to do this.

Records confirmed that staff were up-to-date with training the provider required them to complete for their role. Training included food hygiene, moving and handling, first aid and health and safety. In addition, training records confirmed that the majority of the staff team had received training in dementia care, behaviour that challenges, end-of-life care and mental capacity. Nurses told us they received specific training in relation to the needs of the people living there, such as catheter care training.

Good

Is the service caring?

Our findings

People living at the home said they were happy living there and that the staff were caring. They told us they were satisfied with the way staff interacted with them and said they were treated with dignity, and staff respected their privacy. A person told us, "The carers are lovely, really lovely, not just with me but with everyone." Another person said, "They [staff] are so kind and nice even when they are busy. The people we spoke with stated that they could get up and go to bed at a time that suited them, and spend their day how they wished.

Families too were pleased with how their relatives were cared for and the way staff made them feel welcome. A family member said to us, "You could not get better staff. They are very patient with everyone and seem very well trained." Another told us, "Ever since I have been coming here I have come in at a time that suits me and I have always been made welcome." We spoke with the family member of a person who recently moved to the home. They told us they called at lunch time and had a meal with their relative. They did not have to pay for this and said it was both a lovely and important gesture as it meant they could continue to have a daily meal with their relative like they did when their relative was living with them.

There was a calm atmosphere throughout the inspection. We observed a positive and on-going interaction between people and staff. We heard staff calling people by their preferred name and supporting people in an unhurried, caring and respectful way. They knocked on people's bedroom doors before entering. Staff conversed with people while supporting them with care activities. We heard staff explaining to people what was happening prior to providing care or support. The staff we spoke with demonstrated a warm and genuine regard for the people living at the home. Through conversation it was clear they had a good understanding of people's individual needs and preferences.

There was information in each person's bedroom to provide staff with information about the person's likes/dislikes and preferences, including preferred routines. It also incorporated information about the types of food and drinks people liked. This information is particularly important for staff to have access to if the person is unable to communicate their needs in a coherent way.

There was one shared bedroom in use. The registered manager explained the reason for this and how it was the choice of both people and they had requested to share a room. Facilities were in place to support privacy and dignity, such as a mobile screen between the beds.

The registered manager advised us that they were aware of the local advocacy facilities should they need to use it.

Good

Is the service responsive?

Our findings

People living at the home told us the staff treated them as individuals and that any requests were dealt with promptly. A person living at the home said, "I can do a lot for myself, washing and eating but if I need any help I only have to ask."

Families also told us the home was responsive in a timely way to their relative's particular needs. A family member said, "I feel staff respond well. When I am here people are asking for things all the time and a carer is straight over."

The care plans we looked at were detailed and focused around people's current needs. For example, there was a detailed plan in place for a person who at times became upset and annoyed with staff when they were being supported with their personal care needs. The plan identified triggers and clearly outlined a consistent approach that staff should take in order to minimise distress for the person. Staff we spoke with clearly described how they would respond and this was in accordance with the person's care plan.

The nurses acknowledged that the medicines, particularly in the morning took a long time to administer. We asked a person living at the home and families if medicines were given out in a timely way. The person said they received their medicines on time and family members confirmed their relatives received their medicines at a time when they needed them. We asked the nurses how they ensured people who needed their medicines at specific times received them at that time. One of the nurses told us that a medicine round was undertaken at round at 7.00am for people who needed their medicines before breakfast. Some people were prescribed insulin for diabetes and arrangements were in place for the insulin to be given early in the morning. For people who liked to go bed early, their night medicine was given earlier to support their preferred time of retirement.

The records demonstrated that the person or a family member was involved in the development of the care plans. Most care plans we looked at were signed by the person or a family member. We could see that care plans had been revised to reflect changes to people's needs. Families we spoke with said any changes to the care were discussed with them. A family member said, "The staff discuss things with you. I've signed forms to say I accept the care for my wife." A record was made in the care records when staff made contact with families.

The care records we looked contained a two page document titled 'All About Me'. These were all blank and the registered manager explained that they would be completed if a person went to hospital or moved to another home. We highlighted that if they were complete it would enrich the care records, which we found lacked consistent and sufficient social information about people. The registered manager and directors agreed to consider this.

When we looked around the building we observed that rooms were personalised to each person's taste. People told us they were encouraged to bring in some of their own items, such as wall pictures, ornaments and furniture to create a homely feel. A hairdressing room was available and people could either use the

hairdresser who called regularly to the home or they could bring in their own hairdresser who could use the room.

An activity coordinator had been in post for six months. A variety of activities were in place and these ranged from music afternoons to chair exercises to trips out in good weather. Family members told us, and management confirmed, that the memory boxes from Liverpool museum were popular as they generated conversation and the sharing of memories between people. The activities planned for each day were outlined in the weekly newsletter that each person living at the home received. Staff told us it could be produced in different formats depending on people's needs. For example, the newsletter could be produced in a larger font for people with visual impairment.

People living at the home that we spoke with were aware of how to make a complaint. A person said to us, "The staff are very good but if I had problems I would ask to see the manager." Families were also aware of how to make a complaint about the service. A complaints procedure was in place and this was displayed in the foyer. The registered manager said only one formal complaint had been received and that was in 2015. We were aware of this complaint as the complainant had contacted CQC at the time. We had seen the response the registered manager made, along with supporting documentation. The complaint had been appropriately dealt with in accordance with the provider's policy. The registered manager said they did not get many complaints as any concerns raised by people living there or by families were addressed straight away.

People told us the directors called to see them on a regular basis for a chat and to ask if they were happy with the service. One of the directors confirmed that they had a walk around the home every morning and afternoon, and spoke with people living there and visitors. They showed us the records they kept of suggestions and feedback provided by people and visitors.

'Resident Forum Meetings' were held and we noted one had taken place shortly before our inspection. This was advertised in the weekly newsletter, which also advised that if people did not wish to attend then they could give their topics to the activity coordinator. We also noted in the newsletter that feedback provided about the food had been passed to the catering team.

Good

Is the service well-led?

Our findings

A registered manager was in post and they had managed Warren Park Nursing Home for the last five years.

We asked people living at the home and families their views of the home and how it was managed. We received positive feedback. A person living at the home said, "The manager is very nice. If she is walking past my room she comes in and talks to me; she does care." Another person said, "I have only been here a short while and the staff and the managers are really good." A family member said, "There seems to be a good mix of staff here who know their jobs and are well trained." Another said, "The carers always ask if I am happy with everything and I am. All the staff are really good and caring."

We also asked staff their views of the leadership and how the home was managed. Again the feedback was positive and staff felt supported and involved. A member of staff said, "I like that it is an independent nursing home and it is family run. I like the environment and the people I work with. The manager has an excellent knowledge base and that helps to improve the knowledge of the rest of us." Another member of staff told us, "I feel well supported by the manager and the directors. I see them all the time and can talk to any one of them any time I need to." We were also told by a member of staff that, "The owners [directors] are about a lot. They have a good knowledge of the residents."

We asked people living at the home, staff and the directors for examples of how the service has improved as a result of feedback. For example, nurses told us the introduction of senior carers has meant the seniors coordinating the work of care staff leading to less disturbances for nurses during medicine rounds and other clinical activities. Some of the people living at the home had raised that 5.00pm was too early for tea so this had been addressed and the people now received their tea at their preferred time. A person living at the home had requested a faster internet connection and this had been accommodated. Furthermore, a person found the laptop too heavy to use so the directors had purchased a 'tablet' and had shown the person how to use it.

The main improvement that was mentioned by many staff was the appointment of a registered mental health nurse (RMN). This appointment was made because management had identified that as some people were getting older they were developing needs associated with memory and decision making. Staff, in particular the registered general nurses, told us having an RMN in post was invaluable as it provided them with knowledge and support in relation to the management of people living with dementia, and also supported them with applying the principles related to the Mental Capacity Act (2005). It also meant that in addition to the staff leads for infection control and medicines, the home also had a lead for dementia care.

From our conversations with the directors it was clear they were considering a future which could involve more and more people developing memory needs. They were considering ways to develop the service, in particular the environment, to accommodate such changing needs.

Staff told us that there was a culture of openness and transparency within the home. They said they were aware of the whistle blowing process and would not hesitate to report any concerns or poor practice. All the

staff we spoke with said they would feel comfortable questioning practice. A member of staff said, "I would feel comfortable questioning practice. We have a duty of candour. If you are complicit in bad practice then you are as bad as the person if you don't question their practice." Another member of staff said, "I know about the whistleblowing policy and if I need to I would use it without any hesitation; you have to."

We asked the registered manager about the overarching quality monitoring framework for the service. The home was part of the CQUIN scheme. This is a national scheme which stands for Commissioning for Quality and Innovation. It is designed to focus on quality, innovation and seeks to improve the quality of care. The registered manager collated information each month and forwarded it to a central data base. It meant the manager was routinely monitoring, analysing and reporting on quality and risk issues each month. We could see from the CQUIN reports that the areas reported included: the number of DoLS assessments completed; number of safeguarding referrals made; numbers of complaints received and the number of falls.

In addition to collating data for CQUIN, the registered manager provided us with examples of internal audits. These included the medicines audit that was conducted bi-monthly, the falls audit and care record audit. A detailed dependency assessment tool was in place and the registered manager used this on a monthly basis to monitor the dependency needs in terms of both nursing and care needs. Health and safety meetings were held monthly between the directors and the registered manager. Accidents and incidents were discussed and if appropriate an action plan put in place.

An annual satisfaction survey was conducted and we were provided with the report of the survey produced in December 2015. It included a detailed presentation of the analysed results and an action plan based on the areas identified as requiring improvement.

The manager ensured that CQC was notified appropriately about events that occurred at the home. Our records also confirmed this.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The medicines were not stored securely and safely at all times. Regulation 12(1)(2)(g)