Alma Lodge Care Home

# Alma Lodge Care Home

**Inspection report**

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## Ratings

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

## Overall summary

This was an unannounced inspection and took place on 20 and 21 October 2014.

Alma Lodge is a care home that provides accommodation for up to 14 older people who require a range of personal and care support. Some people were living with a dementia type illness and others lived reasonably independent lives but required support for example with mobilising safely. At the time of the inspection seven people lived there.

There is a registered manager at the home who is also one of the owners. 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.

Medicines were not managed safely or appropriately and there were not enough appropriate hand washing facilities available to staff throughout the home to help prevent cross infection.

When people's needs had changed not all the information had been recorded in their care plans which meant staff did not have up to date information about

# Summary of findings

people's care needs. However, staff knew people well; they had a good knowledge and understanding of the people they cared for. They were able to tell us about people's care needs, choices, personal histories and interests.

Staff had a basic understanding of the Mental Capacity Act 2005 but the use of mental capacity assessments for people who had limited or fluctuating capacity were not in place. This meant that staff did not have recorded information about people's mental capacity.

There was always a manager on duty and staff had a clear understanding of their roles and responsibilities. The registered manager had not notified us of deaths of people, both expected and unexpected, or any allegations of abuse or injury to people as legally required.

Throughout the inspection we saw staff talking with people in a caring and professional manner. People were happy and comfortable in the company of staff. Visitors were made welcome when they arrived at the home. One visitor said, "Staff are very approachable and they listen to what we say." Another visitor said, "My friend is very happy here."

Everyone we spoke with told us they were happy with the food provided. One person said, "The only problem with it is it's so nice I am eating too much."

Everyone told us staff were friendly and approachable and if they had any concerns they would talk to them and were confident they would be investigated.

Staff had received training in how to recognise and report abuse. They were clear about how to report any concerns and were confident they would be investigated. Staff told us they received regular training and supervision. They said they felt supported by the managers and other staff. One member of staff said, "If there's ever a problem you can always talk to them, they're very good." Recruitment records showed that there were systems in place to ensure staff were suitable to work at the home.

People had access to health care professionals including GP's, district nurses and chiropodists to meet their specific needs. Staff told us how they would refer people to the appropriate health care professionals to help them meet their health care needs. Staff told us they would always phone the doctor or district nurse for advice if they were concerned about anybody.

There were a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

Some aspects of the service were not safe.

People's medicines were not managed safely. Staff did not follow their own medicine policy. There were no risk assessments in place for people who self-medicated.

There was not enough appropriate hand washing facilities to prevent cross infection.

Staff had a clear understanding of the procedures in place to safeguard people from abuse.

There were appropriate staffing levels to meet the needs of people.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work at the home.

**Is the service effective?**

Requires Improvement

Some aspects of the service were not effective.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited or fluctuating capacity were not in place.

Staff had received the appropriate training and support to carry out their roles.

People said the food was good and they had enough to eat and drink. They were provided with appropriate assistance and support and staff understood people's nutritional needs.

People were supported to have access to healthcare services this included GP, district nurse, optician and chirpodist.

**Is the service caring?**

Good

The service was caring.

People were supported by kind and caring staff who knew them well.

People's privacy and dignity were respected.

People were involved in developing their own care plans and making decisions about their daily care.

**Is the service responsive?**

Requires Improvement

Some aspects of the service were not responsive.

# Summary of findings

Some of the care records required updating. This meant there was no guidance for staff to ensure consistency or demonstrate evidence that people's care needs were met. However, people received care and support that was responsive to their needs because staff knew them well.

People's opinions were sought, listened to and acted upon through daily and ongoing discussions with staff.

**Is the service well-led?**

**Requires Improvement**

Some aspects of the service were not well led.

The home had not notified us of deaths of people, both expected or unexpected, or any allegations of abuse or injury to people as legally required.

There were no audits in place to monitor the quality of care and support people received. Therefore areas for improvement were not promptly identified and addressed.

The registered manager was aware of the shortfalls in recording care and updating people's care files. They told us what actions they were taking to address this.

One of the managers was always on duty to make sure there were clear lines of accountability and responsibility within the home. There was a positive and open culture at the home. People and staff told us the registered manager was open and approachable.

# Alma Lodge Care Home

**Detailed findings**

## Background to this inspection

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

This was an unannounced inspection by two inspectors and took place on 20 and 21 October 2014.

Before the inspection, we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report. We considered information which had been shared with us by the local authority. We checked to see if we had received any notifications in relation to deaths of people or any allegations of abuse or injury to people as legally required.

During the inspection six people told us about the care they received. We spoke with four members of staff which included the registered manager and deputy manager, two visitors and three visiting healthcare professionals.

We looked around the home and observed how people interacted with staff and each other. We looked at individual care records and associated risk assessments for four people. We viewed four staff files to look at recruitment practices and other records including audits, maintenance records and policies related to the running of the home.

We observed the administration of the lunchtime medicines and inspected the medicine administration records (MAR) for all seven people. We observed how people were supported during their lunch.

We last carried out an inspection at Alma Lodge in June 2013 when we had no concerns.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe at Alma Lodge. Two people told us why they had moved into the home, this included poor mobility and unable to care for themselves on a day to day basis. They said living at the home had made them feel safe. One person said, "I feel so much safer living here." Two visitors told us they felt people they visited were safe at the home. One said, "I don't have to worry any more, I know (my friend) is safe here."

People had not been protected against the risks associated with the unsafe management of medicines. During the administration of lunchtime medicines we observed staff leaving pain relief medicines for two people to take later. There was no information or risk assessments to inform staff it was safe to leave these medicines for people to take later. Some of these medicines were 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. We asked staff how they knew they were giving medicine safely and leaving the appropriate amount of time between doses. Staff told us they could not be sure this happened.

The arrangements for the administration of PRN medicines did not protect people from the unnecessary use of medicines. We saw PRN medication was routinely administered and staff did not ask people if the medicine was needed. There was no guidance in care plans or risk assessments to inform staff why these medicines had been prescribed and when people should take them. Staff told us they knew people well and knew they needed to be given these medicines regularly otherwise they would be in pain. There was no evidence that any discussions had taken place with healthcare professionals to ensure these medicines were used appropriately and people were not receiving more medication than they required.

There was no risk assessment or monitoring in place to check whether one person who administered their own medicines was safe to do so.

There were shortfalls in the arrangements for the recording and storage of controlled drugs (CD's). Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. Not all CD's had been stored legally or recorded accurately. We found CD's in the CD cupboard and in an unlocked filing cabinet had not been accounted for or recorded in the CD book. The people who had these medicines prescribed no longer lived at the home. There was no audit trail or system to ensure CD's were disposed of safely and promptly. Therefore the registered manager did not know how many CD's were stored in the home and if these had been administered correctly.

One person's MAR chart showed the person had not received prescribed medicines on the day of our inspection. The MAR chart stated the medicines had not been administered as it was out of stock. The registered manager told us the medicines had been ordered on that day. This meant the person did not receive their prescribed medication on that day. This could have impacted on their health and well-being as their conditions were not being treated appropriately.

We observed medicines being crushed. The medication policy included guidelines for administering crushed medicines but this had not been followed. Crushing medicines may alter the way they work and make them ineffective. Staff should always ask for a pharmacist's advice before they crush any medicines. A note in the MAR chart dated January 2013 stated the consultant doctor had said this method of administration was acceptable. There was no evidence of any discussions had taken place with the pharmacist to ensure these medicines had been used appropriately or regular reviews had taken place. Staff could not be sure this person was receiving medicine that was effective or the correct dose.

People were not protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was not enough appropriate hand washing facilities throughout the home to prevent cross infection. Fabric hand towels were being used in communal bathrooms and toilets. The floor tiles in the ground floor bathroom had lifted around the toilet area; this was as the result of water damage. There were bars of used soap in this bathroom. There were two body creams one was unnamed and for the other cream for a person no longer at the home. Staff did not know if these were being used by people. This could leave people at risk of harm from cross infection. The ground floor bath, bath mat and bath hoist were dirty. We asked people whether they were able to have regular baths

Requires Improvement

# Is the service safe?

and they told us they were. However, one person said they chose not to because, "It's not really very nice in there." We asked this person why and they told us the bathroom was not very clean.

Staff were responsible for cleaning all areas of the home and had a clear understanding of their responsibilities. They told us the bath was cleaned after it had been used. There were daily, weekly and monthly cleaning schedules in place and these had been ticked as completed but the schedule did not include the baths or hoists. This meant there was no system in place to prevent a reoccurrence of these issues.

People were not protected from the risk of infection because appropriate guidance had not been followed. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff received safeguarding adults at risk training and regular updates. They understood signs of potential abuse if they had concerns they would report this, if appropriate, to the registered manager or deputy manager. They told us if their concerns related to the managers then they would report this to external services. Staff were unable to tell us who they would report to but said they knew where to find the appropriate information which included policies and displayed information on noticeboards. The registered manager told us how they had previously worked with the local safeguarding team when concerns had been identified at the home.

Individual risk assessments were in place for people who lived at the home. These provided information for staff on how to manage identified risks. One person who wished to stay as independent as possible had been identified as requiring support from a mobility aid and on occasion also from staff. The risk assessment informed staff this person was able to take their own risks, was aware of the consequences, and was able to mobilise without help unless they asked. Staff told us what they would do if they identified someone was at potential risk of a pressure sore. They said, "I would ask the district nurse to visit but I would also make sure their position was changed regularly, I may put them on a turn chart and I would put a pressure relieving mattress on their bed." Staff told us they knew people well and were familiar with the risks they presented. They knew what actions to take to support people safely. Records seen and discussions with healthcare professionals confirmed this happened.

There were adequate staffing levels in place. The rotas showed there were two care staff and a member of the management team on duty during the day. There were two staff at night, one of who was a 'sleep-in'. A 'sleep-in' member of staff is somebody who works for an agreed number of hours at the start and end of a shift and may be called on at any time during the night depending on people's needs. People told us, and we saw, staff were always available to help them, one person said, "I never worry about my bell not being answered." During the inspection call bells were answered promptly. Staff told us, and we saw from the rotas, one of the managers or other staff would cover any staff absences or shortages. This included holiday, sickness, or if people were unwell and had increased care needs. This meant they were enough staff on duty.

Staff files contained appropriate information for safe recruitment. This included an application form with full employment history, references, the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults. When needed further enquires about staff had been made. For example references were followed up with telephone calls and where a DBS check had not been returned further enquires were made prior to the person starting work.

Requires Improvement

# Is the service effective?

## Our findings

People received care from well trained and supported staff. People said staff were "Good, and very helpful." One person told us about the improvements they had made with their mobility and confidence, with the support of staff, since they moved into the home. Visitors said staff listened and were very approachable. Staff told us they received regular training and supervision. They said they felt supported by the managers and other staff. One member of staff said, "If there's ever a problem you can always talk to them, they're very good."

Staff did not always follow the principles of the Mental Capacity Act 2005 (MCA). This is an act introduced to protect people who lack capacity to make certain decisions because of illness or disability. Staff told us about a person who did not have capacity to make decisions related to their health needs. One person had their medicines administered covertly. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. There was no Mental Capacity assessment or best interest agreement in place to decide if this was appropriate for this person. Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards(DoL's). They demonstrated a basic understanding of mental capacity but told us they did not have any experience of DoL's. Staff told us how they supported one person who did not have capacity to make decisions for example, about what to wear. They told us they had known this person for a long time so they had an understanding of what they liked which included being warm and well dressed. Care records showed a mental capacity assessment had been completed for one person more recently admitted to the home. The registered manager told us mental capacity assessments would be undertaken for everybody.

Where people did not have the capacity to consent, the registered manager had not acted in accordance with legal requirements. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw staff always asked people's consent before offering them help and made sure the person was happy with what had been provided and did not need anything else. Consent forms were in place for people to sign these included consent to photographs being taken and care and treatment. One person had not signed any of the consent forms, we discussed this with the registered manager who told us this person had agreed to the care but had declined to sign. From time spent with this person it was clear they agreed with and consented to the care they received.

The registered manager told us and we saw from the training matrix that staff received regular training and updates. This included infection control, moving and handling and first aid. We saw from staff files that staff received induction training when they first commenced working at the home. The registered manager also identified further training staff required dependant on the needs of people who lived at the home. For example, a number of people required support with a specific complex health need and appropriate training had been arranged from staff.

Staff told us they were encouraged and supported to undertake further training for example National Vocational Qualifications or care diplomas. They said if they identified any training that would help them to provide better care and support to people the registered manager would support them to attend.

People were supported to maintain a balanced and nutritious diet. Nutritional assessments were in place and these identified people's food and drink preferences, where they liked to eat their meals and any support they required. One person told us about their very specific food choices. This had been documented in their nutritional assessment and we saw these choices were respected. If people did not like the meal that was provided then alternatives were offered. Another person said, "It's good, homely, home cooked food." Someone else said, "The only problem with it is it's so nice I am eating too much." Staff told us because they knew people so well they were able to provide meals everybody liked. We saw hot and cold drinks were served regularly throughout the day. Staff told us although hot drinks were served at set times, people were able to have a drink whenever they wished. People told us the food was good and there was plenty of it.

Staff and nutritional risk assessments identified when people were at risk of inadequate nutrition. Care records stated people should be weighed monthly and although people were weighed regularly they were not weighed every month. Staff told us they knew people well and they knew what they were eating therefore they would identify if

Requires Improvement

# Is the service effective?

anyone was at increased risk of weight loss. One member of staff explained, "If (resident) doesn't eat lunch I check at supper time and if they're still not eating I will start a food and fluid chart. That way we can all keep an eye on what's going on." Staff used innovative ideas to encourage people to drink adequate amounts. One person who required support did not recognise when they were being offered drinks. By adding a thickening agent to the drink the person became aware of the fluid and was able to drink adequate amounts.

People were supported to have access to healthcare services and maintain good health. Care records showed external healthcare professionals were involved in supporting people to maintain their health. This included GP, district nurses, optician and chiropodist. We spoke with three healthcare professionals who told us the staff referred concerns to them appropriately when a need was identified. People who told us about their health needs said they were able to see their doctor when necessary. One member of staff said, "If there's anything not right we always phone the doctor or district nurse for advice."

Good

# Is the service caring?

## Our findings

People were supported by kind and caring staff. People told us staff were good and treated them with respect. One person said, "I'm treated with kindness and looked after as needs be." Another person said, "They are very nice people, very lovely, they could not do better."

All staff had a good knowledge and understanding of the people they cared for. They were able to tell us about people's choices, personal histories and interests. One member of staff told us, "I know everybody really well, I only have to go into someone's bedroom and I instantly know if something's wrong. When you know people you can tell." This staff member then told us how they would spend time with someone who wasn't happy to support them and resolve their concerns. People told us they were able to choose how they spent their day. Some people spent time in their bedrooms. We observed staff asking these people if they would like to sit in the lounge for a while, staff respected people's decisions when they declined. One person said, "I like to watch television and read my books, I don't like talking with other people." Another person said, "I read a lot, I prefer to be on my own." People told us they had enough to do and did not get bored.

Throughout the inspection we saw staff talking with people in a caring and professional manner. We heard staff chatting to people about their day and laughing about incidents that had happened the previous day. There was friendly 'banter' between people and staff. People were happy and comfortable in the company of staff. Visitors were made welcome when they arrived at the home. One visitor said, "Staff are very approachable and they listen to what we say." Another visitor said, "My friend is very happy here."

Staff had a good understanding of the needs of people who were unable to express themselves verbally due to their dementia type illnesses. Staff told us they used the information they had about people to help them make choices. People were relaxed in the company of staff and responded positively when staff engaged with them.

People's care records showed they had been involved in developing their care plans. When people moved into the home staff spent time getting to know the person to assess their needs, choices and preferences and this was recorded in their individual care plans. Staff told us and care plans demonstrated that people were supported and encouraged to maintain their own independence. One person told us how they had been supported to regain their independence. They said they were able to do more for themselves in relation to personal care and making their own decisions than prior to moving into the home.

During the day we saw staff responded to people's requests for help appropriately and in a timely way. If staff were unable to attend to people immediately they checked to make sure the person was not in need of urgent assistance and told them when they would be able to attend. We saw people were supported by staff in a discreet and respectful way.

Staff supported people and their privacy and dignity was respected. All of the bedrooms were single occupancy and where people chose to they had been personalized with their own belongings such as photographs and ornaments. People were able to spend time in private in their rooms as they chose. Bedroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. One person said they felt unwell and wished to remain in their room undisturbed, staff respected this. Later, when they felt better, we saw staff attending to this person.

Requires Improvement

# Is the service responsive?

## Our findings

People were involved in developing their own care plan. One person told us how the staff had spent time talking to them about the care they needed and their choices about how this was provided. This included morning, daytime and bedtime preferences. There was a weekly activity programme and staff supported people to take part in these and other activities during the week as people wished. Care plans contained information about people's interests and hobbies and they were supported to maintain these. One person said, "I've always been an avid reader so I am never bored." Another person told us they had plenty to do during the day they said, "I watch TV and do crosswords, they (staff) offer to take me out but I don't want to go."

Before people moved into the home the registered manager carried out an assessment to make sure the home would be able to provide them with the care they needed. Care plans were completed with the person and included information about their likes, dislikes and choices as well as their needs. The registered manager told us care plans were reviewed monthly with people. Although care plans had been reviewed regularly they had not been reviewed monthly. Staff knew people, their individualities and needs really well however when people's needs had changed not all the information had been recorded in their care plans. For example one person's care had changed in relation to their pressure area management. Staff described to us the care this person required and how they ensured they received including regular changes of position which had been recorded on a turn chart. However, the care plan had not been updated to reflect this. Some people had support from staff to help them meet specific complex health needs; this had not been recorded in individual care plans. This meant there was no guidance for staff to ensure consistency or demonstrate that people's care needs were met. Although people received the care and support they required, their current needs were not always reflected accurately in the care plans and this requires improvement.

We asked staff how they kept up to date with changes in people's needs. They told us they read the handover diary which contained this information. This was completed throughout the day. For example one person had presented as unwell, staff had recorded they had tested this person's urine (as they were prone to urinary tract infections), and they had encouraged the person to drink more. There was information for other staff to contact the GP if there were no improvements. The following day staff had recorded the person had improved. This information had not been recorded in the person's care plan or daily notes. Staff told us because they knew people really well and the handover diary contained current information they did not rely on care plans to inform them about people's needs. This meant there was no evidence that staff had accurate information about people's current care needs.

Visiting professionals told us staff looked after people really well and provided a high standard of care. One professional told us, "They (the staff) give good care, they look after people well. They phone for advice when they need to but they're equally good at working on their own."

People's wishes in respect of their religious needs were respected. People who wished to were supported to attend local churches and a religious service took place during the inspection. People told us this was something they liked to take part in.

There was a complaints policy at the home. People said they did not have any complaints at the moment but if they did they knew who to report them to, they said they were always happy to speak to the registered manager. One person said, "I would speak to whoever came to me first, if anything was wrong I would let them know." Another person said, "If anything was wrong I would soon tell them." Visitors told us staff dealt with any concerns immediately. We looked at the complaints book and saw when people had raised a concern this was recorded along with any actions taken to address the concern. For example a group of people had complained the portion size of lunchtime meals was too big therefore smaller portions had been provided. There had been no formal complaints at the home during the past year.

Requires Improvement

# Is the service well-led?

## Our findings

People told us the registered manager or deputy manager were always available to speak to them. They told us they were 'very good,' 'always available' and they 'could talk to them at any time'. Staff confirmed there was always a manager available. Visitors told us the managers were approachable and said they could raise any issues with them or a member of staff.

A registered person (provider or manager) must send notifications about deaths at the home to the Care Quality Commission without delay. The registered manager had not notified us of any deaths of people both expected and unexpected. This meant that we did not have the opportunity to assess if the events affecting people who used the service needed CQC to take further action if required.

The registered manager had maintained a record of deaths that had occurred at the home.

We asked the registered manager to submit the relevant notifications for deaths that had occurred during 2014. These had not been received at the time of writing this report. The registered manager told us they were aware notifications needed to be submitted.

The registered manager had failed to notify the CQC of any deaths of people who used the service. This is a breach of Regulation 16 of The Care Quality Commission (Registration) regulations 2009.

A registered person (provider or manager) must send notifications about incidents that affect people who use services to the Care Quality Commission without delay. The registered manager had not submitted any statutory notifications or notified us of any allegations of abuse or injury to people who lived at the home. This meant that we did not have the opportunity to assess if the events affecting people who used the service needed CQC to take further action if required.

The registered manager had maintained a record of incidents and injuries that had occurred at the home. The incident forms contained a description of the incident, what treatment was given and actions taken to prevent a recurrence. We asked the registered manager to submit the relevant notifications for injuries that had occurred during 2014. These had not been received at the time of writing this report. The registered manager told us they were aware notifications needed to be submitted.

The registered manager had failed to notify the CQC notifications about incidents that affected people who used the service. This is a breach of Regulation 18 of The Care Quality Commission (Registration) regulations 2009.

The registered manager promoted a positive culture that was open and person-centred. They said the purpose of the home was to provide care and support for people in an environment that reflected a family home. Staff and managers told us it was important the home was a "proper home" for people. One member of staff said, "I know people so well it's like caring for my family." Another member of staff said, "It's their (people's) home they can do what they like." Staff and people told us they were able to talk to the registered manager about any concerns they had and be confident they would be listened to and acted on.

There were some quality assurance systems in place to monitor safety inside and outside the home. A maintenance plan identified areas around the home that required work and when this work would be achieved. Some general decorating had taken place around the home in the past year. We saw regular gas, electrical, lift and hoist services had taken place and a fire risk assessment had been reviewed this year. However, there were no audits in place to monitor the quality of care and support people received. For example there were no care plan audits or accident and incident audits. Therefore areas for improvement were not promptly identified or addressed and this requires improvement.

The registered manager and the deputy manager had an active role in the day to day running of the home, with one of them working in the home each day. The registered manager had a good knowledge of people, their needs and choices. They said they had a good staff team and were confident staff would talk with them if they had any concerns. We saw people and staff were very relaxed with the management team and we observed then chatting and laughing happily together. Everybody we spoke with told us they were happy to talk to and raise concerns with the management team, they said they were supportive and approachable. Staff members gave us examples of when

Requires Improvement

# Is the service well-led?

they had raised concerns and how these had been addressed. One staff member said, "I spoke with (registered manager) and told them my problem, they listened and understood. It was dealt with."

The registered manager supported staff to be involved in the day to day running of the home. A senior care worker had recently been supported to take responsibility for staff supervision. This person told us it was something they enjoyed but had discussed it with other staff prior to taking on the role to ensure they felt comfortable with the arrangement. This person said, "Some people may have issues they don't want to discuss with me, that's fine, everyone knows they can discuss it with (registered manager)."

There had been concerns identified by a member of staff in relation to the duty rota. They discussed the issues with the registered manager and arranged a staff meeting. They explained they had done this as part of their own personal development but also to prevent any discontent escalating and affecting people who lived at the home. The meeting had only recently taken place and there were no minutes currently available. One to one feedback had been provided for one member of staff who had not attended.

We were told resident meetings were held but these were not recorded. Feedback surveys had not been undertaken in the past but there was no current information. The registered manager showed us copies of questionnaires they were planning to send out shortly. These included resident, relative and stakeholder surveys. We saw people's views about the running of the home were gathered informally as an ongoing process, this happened at care plan reviews and generally on a day to day basis. People told us they were confident to raise both positive and negative issues with the staff and felt they were listened to. For example one person told us they had complained about the heat in their bedroom during the summer so a fan had been provided.

The registered manager was aware there were shortfalls in the recording and updating of people's care files. They told us how they had worked with the local safeguarding team when concerns had been identified at the home. As a result a new format of care planning had been introduced to better suit the needs of people who lived at the home. The registered manager was working with staff to support them becoming involved in the assessment and review of people's care plans. We were shown checklists that were being introduced which would be completed regularly. These were to support staff to ensure the care plans reflected people's current needs.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>People who use services and others were not protected against the risks associated with unsafe use and management of medicines. Regulation 13. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br><br>People who use services and others were not protected against the risks associated with the maintenance of appropriate standards of cleanliness and hygiene. Regulation 12(1)2(c)(i)(ii) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. Regulation 18. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services<br><br>Notification of death of service user.<br><br>The registered person had failed to notify the Care Quality Commission of any deaths of people who used the service. Regulation 16(1)(a)(c) |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>The registered person had failed to notify the Care Quality Commission about any incidents that affected people who used the service. Regulation 18(1)(2)(a)(e). |