Methodist Homes

Riverview Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Our inspection of Riverview Lodge took place on 28 November 2018. This was an unannounced inspection.

Riverview Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is situated in Kingsbury and is registered to provide care to up to 36 older people living in three units. At the time of our inspection there were 35 people living at the home, many of whom were living with dementia.

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 2008 and associated Regulations about how the service is run.

At our previous inspection of Riverview Lodge in March 2016 we gave the home a rating of Good.

People who lived at the home told us that they felt safe, and this was confirmed by family members whom we spoke with.

People had care plans and risk assessments which were person centred. However, these had not always been updated to ensure that they fully reflected changes to people's health needs and the support they required with these. Behavioural charts had not always been completed by staff to show they had followed guidance contained within a person's care plan. This meant that we could not be sure that people always received the support they required.

Daily records of people's care were otherwise well maintained. Systems were in place to share information between outgoing and incoming staff at shift changes.

There were systems in place to review and monitor the quality of the service, and we saw that action plans had been put in place and addressed where there were concerns. However, the home's quality assurance systems and regular care plan reviews had failed to identify where there had been changes to people's health needs which had not been included in their care plans. There was no regular monitoring of behavioural records which did not always show if staff had followed the guidance contained within a person's care plan. This meant that we could not be sure that people's needs were being safely met. The registered manager told us that there would be an immediate review of people's care records.

People's nutritional needs were met and their food and fluid intake was recorded and monitored. Choices were available at mealtimes and alternatives were provided to people with religious or cultural needs and

preferences. However, we found that the home's menus were designed by the provider and people had not been consulted or involved in making decisions about what they included.The registered manager told us that they would ensure that regular food satisfaction surveys would be conducted in future and these would be used to make changes to menus where required.

People were protected from the risk of harm or abuse. Staff members had received training in safeguarding and were able to demonstrate their understanding of what this meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

Medicines at the home were well managed. People's medicines were stored, managed and given to them appropriately. Records of medicines were well maintained.

Staff at the home supported people in a caring and respectful way and responded promptly to meet their needs and requests. There were enough staff members on duty to meet the physical and other needs of people living at the home. People who remained in their rooms for part of the day were regularly checked on.

Staff who worked at the home received regular relevant training and were knowledgeable about their roles and responsibilities. Appropriate checks took place as part of the recruitment process to ensure that staff were suitable for the work that they would be undertaking. All staff members received regular supervision from a manager, and those whom we spoke with told us that they felt well supported.

The home was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. However, we found that some people's capacity assessments had not always identified the decisions that they were able to make. The registered manager told us that this would be addressed. Staff members had received training in MCA and DoLS, and those we spoke with were able to describe their roles and responsibilities in relation to supporting people who lacked capacity to make decisions.

The home provided a range of individual and group activities for people to participate in throughout the week. Staff members engaged people supportively in participation in activities. People's cultural and religious needs were supported but this was not always identified in people's care plans.

The home had a complaints procedure. People and their family members told us that knew how to complain if they were unhappy with anything.

Staff at the home liaised with health professionals to ensure that people received the support that they needed. Local health professionals visited the home regularly.

We saw that the registered manager and deputy manager spent time supporting people. People who lived at the home, their relatives and staff members spoke positively about the management of the home.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made one recommendation.

Further information is contained in the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Risk assessments were clearly linked to guidance in people's care plans how to manage identified risks.

Staff we spoke with understood the principles of safeguarding adults, how to recognise the signs of abuse, and what to do if they had any concerns.

Medicines were well managed and recorded.

Is the service effective?

Requires Improvement

The service was not always effective. Although people were offered choice at mealtimes they had not been consulted or involved in developing the menus they were offered.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007 had been met.

Staff members received the training and support they required to carry out their duties effectively.

People were supported to maintain good health and to access health services when they needed.

Is the service caring?

Good

The service was caring. People and family members told us that they were satisfied with the care provided by staff. We observed that staff members respected people's privacy and dignity.

Staff members spoke positively about the people whom they supported, and we observed that interactions between staff members and people who lived at the home were caring and respectful.

People's religious needs were respected and supported.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans did not always include up to date information about people's health care needs.

One person's behavioural charts did not always show if staff members had followed the guidance contained in their care plan.

People were supported to participate in a range of individual and group activities.

The service had a complaints procedure and people and family members knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service not always well led. However, although systems were in place to monitor the quality of the service we noted that these had not always identified failures to ensure that information in relation to people's health needs were recorded in their care plans or that staff members always followed guidance in relation to behavioural support.

The registered manager demonstrated leadership and accountability. She was approachable and available to people who used the service, staff members and visitors.

Staff members told us that they felt well supported by the manager. People and family members of people who used the service felt that the home was well managed.

The registered manager had a good working relationship with health and social care professionals and organisations

Riverview Lodge

Detailed findings

Background to this inspection

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

This scheduled inspection took place on 28 November 2018 and was unannounced. The inspection team comprised of three inspectors.

During our inspection we spoke with eight people who lived at Riverview Lodge and seven family members. We also spoke with seven care staff, a cook, the maintenance officer, the deputy manager and the registered manager. We also met and spoke with two visiting health professionals. We spent time observing care and support being delivered in the main communal areas. We used the short observational framework for inspection (SOFI), This is a tool designed to observe and assess the care provided to people unable to communicate verbally. We also looked at records, which included nine care records, nine staff records and records relating to the management of the service. These included records of medicines administration, health and safety and quality assurance reports.

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 reviewed the information included in the PIR along with other information that we held about the home such as enquiries and notifications.

Good

Is the service safe?

Our findings

People and family members told us that the care provided by the home was safe. One person said, "I do think they are helping me to be as safe as I can be," A family member told us, "I can go home knowing [relative] is safe."

People's risk assessments were personalised and had been completed for a selection of areas including people's behaviour, medicines, falls, pressure ulcers, infection control and moving and handling. We saw that these were up to date and had been reviewed on a regular basis. Risk management plans were included in people's care plans and we saw that these had been cross-referenced to the relevant risk assessment. Behavioural risk assessments included guidance for staff around providing positive approaches to supporting people. We noted that a risk assessment in relation to one person's behaviour was not easily identifiable. We discussed this with the registered manager who showed us that the risk assessment had been completed. They told us that they would ensure that it was made easily accessible to staff.

The home had an up to date policy on safeguarding. Staff members that we spoke with demonstrated that they understood the principles of safeguarding, and how they would respond to and report suspicions and concerns that a person may be at risk of abuse or harm. We saw that training in safeguarding had been received by all staff members. We looked at the safeguarding records for the home which showed that safeguarding concerns had been appropriately managed.

Medicines were stored, managed and recorded appropriately, and administered to people safely. An up to date medicines policy which included procedures for the safe handling of medicines was available to staff. Staff administering medicines had received training in administration of medicines. Guidance was in place for people who received PRN (as required) medicines. Weekly monitoring of medicines took place and we saw that 'spot checks' were also undertaken. We were told that an audit of medicines took place on a quarterly basis and we could see records that showed that this was the case. Staff members administering medicines were also responsible for checking medicines and records. A recent medicines error had been very quickly identified and appropriate action had been taken to ensure that the person was safe. An action plan had been put in place to reduce the likelihood of errors in the future

The service had made arrangements to ensure that there were sufficient staff members in place to support people's needs. We looked at the home's staffing rotas which showed that between 8am and 8pm there were always two care workers and one senior care worker on duty on each floor, supported by the registered manager and deputy manager. Between 8pm and 8am, a waking night care worker was available on each floor. In addition, the home had an activity co-ordinator, catering staff and domestic workers. During our inspection we observed that staff members were present in the communal areas of the home and regularly checked on people who chose to remain in their rooms.

We also observed that people received care and support when they required. Staff members responded promptly to ensure that people were provided with the assistance they needed. There were enough staff to support people to take part in activities. People, family members and the majority of staff members that we

spoke with told us that there were enough staff on shift to meet the needs of people living at the home. One person said, "When I call the staff they come straight away." The registered manager told us that they regularly reviewed people's care and support needs and that additional staffing would be provided if required.

The staff records we looked at showed that appropriate recruitment and selection processes had been carried out to ensure that staff were suitable for their role in supporting people who used the service. These included checks of references relating to previous employment and of criminal records.

The home had procedures in place to reduce the risk of infection. Staff members were seen wearing disposable aprons and gloves when supporting people with their care. We also observed that catering and domestic staff used appropriate protective clothing. Anti-bacterial hand rub was located in several areas of the home to minimise the risk of spread of infection. Guidance for good hand washing was displayed in bathrooms. Soap and paper towels were accessible in bathrooms.

Checks of equipment were carried out. Moving and handling equipment, such as hoists and the home's lift were inspected and serviced regularly in accordance with the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.

Temperatures of fridges and freezers, hot water temperatures and the storage of medicines were monitored closely.

An annual fire risk assessment had been carried out by the provider. Fire safety guidance was displayed and fire equipment had been regularly serviced. Fire drills were carried out quarterly and we noted that these included drills that had taken place during the night. Emergency evacuation plans had been developed for people and were maintained in their care files.

Accident and incident records were well recorded and showed that appropriate actions to address concerns had been put in place. The provider maintained an out of hours emergency contact service and staff we spoke with were aware of this.

Actions had been taken to reduce health and safety risks to people and staff. Regular health and safety checks and audits had taken place. The home had a maintenance officer, and we saw that maintenance issues had been reported immediately and dealt with in a timely manner.

Requires Improvement

Is the service effective?

Our findings

People that we spoke with were positive about the support that they received from staff members. One person said, "They are very good here. I have everything I need." A family member told us, "The staff treat my relative very well."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The care records that we viewed showed that assessments relating to people's capacity to make decisions had been undertaken and that these followed the code of practice associated with the MCA. However, the assessments were variable in the quality of information that they contained which meant that we could not always be sure about the type of decisions that people were able to make. The registered manager said that she would discuss this with the staff team to ensure that they understood how to complete an assessment record.

We saw that DoLS authorisations had been sought for people who were under continuous supervision and unable to leave the home unaccompanied due to risk associated with lack of capacity to make decisions. A system was in place for ensuring that applications for renewals of DoLS authorisations were made in a timely manner.

Training in MCA and DoLS had been provided to all staff at the home and the staff members that we spoke with were aware of the requirements of the MCA. The registered manager and deputy manager demonstrated that they understood the importance of MCA and DoLS and their responsibilities in relation to these.

People were asked for their consent with regards to care planning and risk assessment and this was recorded in their care plan. Where people were unable to record consent, the home asked family members or other representatives to support any such decisions. We saw, for example, that a person's family had been involved in a best interest's decision about their safety in leaving the home unaccompanied.

Staff members working at the home received the training and support that they required to support people's needs. Staff training records showed that all new staff members had received induction training

that met the requirements of the Care Certificate for staff. The Care Certificate is a nationally recognised qualification which provides training in a range of core outcomes for new staff in health and social care services. We saw evidence that core training had been provided to all staff and that this was refreshed on a regular basis. The home's training programme included additional training sessions relating to people's needs. For example, dementia awareness, Parkinson's awareness, positive behavioural approaches and end of life care. The home's training matrix showed when training had been received, or was due, for each staff member. This was reviewed on a weekly basis, and we saw that training had been booked for staff members requiring refresher training.

Staff members that we spoke with told us that they received the support that they needed to undertake their duties effectively. The records that we viewed showed that staff had received supervision from a manager on a regular basis and that annual performance appraisals had taken place during the past year. One staff member said, "I have supervision every two months. There is always someone I can talk to if I need support or advice immediately."

People's health care needs were met and monitored. Records showed that people regularly received health checks. They had access to a range of health professionals including; GPs, dieticians, opticians, chiropodists, psychiatrists, and dentists. They also attended hospital appointments. During our inspection we met with two healthcare professionals who told us that they visited the home regularly. The registered manager told us that she attended regular meetings of the Brent Enhanced Health Care in Care Homes Project and found this to be a useful forum for discussing the wider healthcare needs of people living at the home.

The home's environment was suitable for the needs of the people who lived there. People told us they were happy with their bedrooms and the layout of the home. People could use a lift to move between floors and there were hand rails on each corridor to aid mobility. The garden was accessible for wheelchair users. The home had recently been refurbished and lighting had been improved to assist people's orientation. Spaces around the home were being developed into themed 'memory corners' with seating where people could relax.

People told us that they were happy with the food that was provided by the home. However, two family members told us that they felt the food could be improved.

The weekly menu was displayed on the walls in the dining area, and daily menus were on each table. There were at least two choices provided for each meal and, where people did not want what was on the menu, we saw that they were offered alternatives. Special diets and individual preferences were catered for. We spoke with the cook who showed us daily eating plans for people with requirements or wishes that were not met by the home's regular menus. For example, halal meat was provided for a person who was Muslim, and another person had a Caribbean meal at least twice a week. A person told us that they were provided with food related to their culture which they enjoyed. On the day of our inspection we saw that the choices for the evening meal both included pork. An alternative meal was provided for a person who did not eat pork for religious reasons.

The cook told us that the menus were seasonal and devised by the provider. We saw that menus were discussed with people at residents' meetings. However, there was no evidence that people were involved in developing the menus that were provided to them.

We recommended that the provider puts a process in place to ensure that people living at the home are regularly consulted and involved in developing their menus.

We discussed this with the registered manager. They told us that they would ensure that a regular food satisfaction survey was put in place and that the responses to this would be used to develop future menu choices.

People were offered hot and cold drinks throughout the day along with fresh fruit and biscuits for snacks. Prescribed nutritional supplements were available to people with poor appetites. People's nutritional needs were assessed and monitored, and guidance for staff members on supporting people with dietary needs and poor appetites were contained within care plans. The care records we viewed showed that people's daily food and fluid intake was recorded and monitored where there were concerns about appetite. Where there were concerns about weight loss or poor food or fluid intake we saw that relevant professionals, such as a GP or dietician, were consulted and guidance developed for staff.

Good

Is the service caring?

Our findings

People and their family members told us that staff members were caring. One family member said, "The carers are devoted. I admire the staff. My relative can be difficult. They treat my relative with respect and also all the other residents." Another told us, "The staff are amazing. They talk to people so nicely." One person told us, "They are fabulous. I really like living here." Another person said, "I'd rather be in my own home, but I can't fault the staff. They are very good to me." One family member told us that some staff did not always chat with their relative, "But there are other staff who are wonderful with him."

We observed that staff members interacted with people in a positive and respectful manner. We saw staff initiating conversations with people and chatting to them with them when providing support. A care worker told us that she gets to know people by talking with them, their relatives and with the staff team. The care worker said that they read people's care plans regularly as it was the care workers who updated the care plans.

People were supported to maintain their relationships with friends, family and others important to them. The registered manager told us that where people's partners and other family members visited, staff members were encouraged to ensure that they had privacy. One family member said, "I am here every day with my [relative] and the staff give us privacy. They always check before they come in." We observed that when a person received a visit from their partner they were able to spend time with them privately in their room without interruption.

We asked about the home's approach to supporting people's sexuality. The registered manager told us that the importance of respecting people's relationships and preferences had been discussed with staff members at team meetings. She said that that, although there was no-one currently living at the home who identified as LGBT, anyone who did would be supported in line with the provider's policies on equality and diversity.

We observed that where people required personal support, this was provided in a timely and dignified manner. Some people chose to spend time in their rooms. We saw that staff members checked on their welfare regularly and asked them about any needs or wishes in relation to care and support. We noted that they knocked on people's doors and announced themselves before going in to their rooms.

Staff members spoke positively about the people whom they supported. One told us, "I really enjoy working here. Sometimes it's a bit difficult, but our residents are lovely, and when they are challenging I try to think about how I would feel if I was in a care home."

Family members that we spoke expressed satisfaction with the information and contact that they received from the home. A family member said, "They always let me know if there is a problem." Another told us, "I am involved in reviews and meetings about [relative's] care."

People's care plans included information about preferences in relation to communication needs and the

delivery of personal care. The care plans were personalised and included guidance for staff members on how to support people. We saw, for example, a staff member interacting with a person using simple language and gestures which the person indicated that they understood. Another staff member gently checked that a person with dementia understood what they were saying to them and gave them time to respond.

People's care plans also included information about their histories, interests, cultural backgrounds and faiths. The staff members that we spoke with were knowledgeable about people's individual cultural needs and interests. The home had a designated chaplain who visited regularly and a priest from another faith group who visited weekly to provide pastoral care. During our inspection the chaplain was visiting the home. We saw that they knew people well and engaged in activities that were taking place.

Requires Improvement

Is the service responsive?

Our findings

A family member told us that their relative had a key worker. We saw that the names of people's key workers were identified on their room doors. A staff member said, "The key worker system works well. Families have a person to contact who knows the person well." A family member said, "I know [relative's] key worker. They are very helpful."

The registered manager told us that, before any new person moved to the home, she assessed the individual care and support needs of the person to determine if the service could meet their needs. We saw that people's needs assessments were detailed but one person's assessment did not include information in relation to their cultural needs and preferences.

People's care plans included information about, for example, people's histories and personal interests, communication, health support, behaviours, mobility and dietary needs. The plans included guidance for staff on how they should support people to meet their individual needs, and were linked to their risk assessments where appropriate. However, we found that the plans had not always been updated to include guidance for staff in relation to particular health conditions. For example, we saw that a person had attended a diabetes clinic and found to have a diabetes-related eye condition. Although a follow-up letter had been received from the clinic identifying actions to reduce the condition worsening, these had not been added to their care plan. This meant that there was no guidance in the person's care plan to ensure that staff members were supporting them effectively to reduce the impact of their condition.

Information in relation to specific dementia conditions in two people's care plans was not always clear. For example, a person had been diagnosed as living with Alzheimer's, and, although their care plan mentioned dementia we found that the diagnosis of Alzheimer's was included elsewhere in their care records. People's care plans included guidance in relation to behaviours that were considered challenging, the recording of one person's behaviours was limited. Their care plan included guidance on techniques to de-escalate behaviours when they occurred. Although staff members completed behavioural charts, they had not always recorded the consequent actions they had taken to reduce the person's anxieties and behaviours. This meant that we could not be sure that staff members followed the guidance contained within the care plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these failures with the registered manager. They said that these issues had not been identified during the home's quality assurance monitoring, but that they would address this with staff and ensure that a full review of people's care files took place in the immediate future.

Staff maintained care notes for each person. The care notes included information about activities, health issues and any regular monitoring of the person's needs that was taking place and were read by staff members at the start of each shift. Medical appointments and visits by health professionals were recorded

along with the outcome for each. Important information was passed on to incoming staff members at a 'handover' at the beginning and end of each shift.

A range of activities took place at the home including a weekly film show based on people's requests, arts activities, quizzes, visits from pets as therapy dogs and exercise sessions. We saw from the activities programme that cultural and seasonal activities had taken place. During our inspection we saw people making Christmas decorations. One person was having a manicure and other people listened to music of their choice. The home had recently participated in a project called 'Bolder Voices', which is a community based choir for older people. During our inspection we saw people watching a video they had made as part of this project, where songs had been developed based on their experiences. We observed people singing along to the video. One person said, "This is really good. I love singing but don't do it so much now." Another person who featured in the video told us, "I loved doing this and love watching it now."

The home had its own hairdressing salon and a hairdresser visited regularly. There was also a shop where people could choose and buy small items such as toiletries and confectionery. The registered manager told us that outings were regularly arranged for people, for example, shopping trips and visits to places of interest and we saw records of these activities.

Monthly residents' meetings took place on each unit. We saw that the records of recent meetings included topics such as activities, Diwali and Christmas celebrations at the home, making complaints, redecorations and refurbishments and menus. Family members were also invited to meetings on a quarterly basis to discuss their views of the support provided by the home.

The home had a complaints procedure which was available in an easy read format. People and family members told us that they felt able to complain if they had any concerns. One person said, "I would talk to staff but I am happy so far and have no complaints," A family member said, "I speak to the manager. She listens and sorts things out straight away." We looked at the home's complaints log and saw that complaints had been addressed quickly and to people's satisfaction.

Peoples' care plans included information about their end of life preferences. This included information about whether people wished to remain at the home or be admitted to hospital, along with information about how they would like to be supported. Some end of life plans had not been completed. The registered manager told us that this was a difficult subject for some people to discuss and the home's approach was to build up a picture gently and in their own time, involving family members where appropriate.

Staff had received end of life support training. During our inspection one person was receiving palliative care, and the staff worked in partnership with palliative care nurses who visited the home regularly. We spoke with a care-co-ordinator from the local hospice who was attending a meeting with a person and their next of kin. They said that staff at the home had attended training provided by the palliative care team and were, "very responsive." They also told us that, "I have developed a good relationship with the staff. They all know me and we work in partnership." The care co-ordinator told us that they were working with the home and other health professionals to set up a monthly multi- disciplinary meeting to review and support decisions and actions in relation to people's care at the end of life.

Requires Improvement

Is the service well-led?

Our findings

People told us that they knew the registered manager and liked them. A family member said, "The manager is very helpful. She does her best to sort things out if there are any problems."

The registered manager was supported by a deputy manager. Senior care workers were responsible for each unit, and were supported by the registered manager and deputy manager.

The staff members that we spoke with told us that they felt that the manager was supportive and approachable. Family members told us they felt that the home was well managed. We saw that the manager and deputy manager spent time on the units and communicated positively with people who used the service, their visitors and the members of staff who were on shift. A family member said of the registered manager, "She is a hands-on manager, always aware of everything."

Staff members spoke positively about the management team and the support that they received. A care worker told us, "I enjoy working here. The team can speak out and I always feel I am listened to." We saw that staff meetings had taken place regularly and the minutes of these showed that quality assurance and issues in relation to people's care and support needs were discussed.

There were systems in place to monitor the quality of service and we saw recorded evidence of these. We saw that quarterly health and safety monitoring took place, along with six monthly audits of systems and practices in relation to care. Food safety audits took place on a six-monthly basis, and an annual infection control audit had been undertaken during the past year. We saw monthly monitoring records of care plans, medicines, falls, infection, and people's weights. Each of the monitoring records contained information indicating reasons for any concern, along with action plans with timescales for completion.

However, we found that there had been failures to ensure that care plans and behavioural records included up to date information in relation to people's needs and the support that they received. The registered manager told us that their formal quality monitoring process was designed to ensure that a sample review of people's care plans were reviewed by a senior senior manager on an annual basis so it was possible that failures to update some people's plans had not been identified. However, monthly reviews of people's care plans and records had taken place at the home, and these had not identified the failures that we had found in relation to four people's records. This meant that that we could not be sure that care plans were systematically updated every time there was a change in people's needs and that records such as behavioural charts were regularly monitored to ensure that staff members always followed agreed guidance.

We discussed this with the registered manager who told us that she would ensure that a review of all care records would take place following our inspection.

Regular monitoring of incidents, accidents and 'near misses' had also taken place and the provider had promptly submitted notifications to CQC where required. The records that we viewed confirmed this.

Satisfaction surveys took place annually. The most recent survey of the views of people who lived at the home and their family members had been analysed and showed high satisfaction rates. Where issues had been raised, actions had been taken to address these. The visiting professionals that we spoke with during our inspection spoke positively about the management of the home. One said, "They are certainly one of the better services that we visit."

We reviewed the policies and procedures maintained by the home. These were up to date and reflected good practice guidance. There was a process in place to ensure that staff members were required to sign when they had read the policies.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9(1)(3)(b) The provider had failed to ensure that people's care plans and records reflected their current needs.