Allenbrook Nursing Home Limited

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

Summary of findings

Overall summary

This inspection took place on 27 and 29 June 2018 and was unannounced. We last inspected this service on 1 and 2 November 2017. At our last inspection, we identified five breaches of the regulations and rated the service 'Requires improvement' overall. Following the last inspection, we met with the provider to discuss what they would do and by when, to improve the overall quality of the service. We also took enforcement action in relation to our concerns about the governance of the service. This enforcement action required the provider to share monthly audits with us outlining their oversight and governance of the service.

At this inspection, we found one breach of the regulation had been met and some improvements have been made. However, the provider was still in breach of four regulations related to safeguarding, safe care and treatment, good governance and notifying the Commission of specific events and incidents as required. We have rated the service 'Requires improvement' overall for a fourth time. We have decided the provider is still required to submit monthly reports to the Care Quality Commission because sufficient improvements have not been made since our last inspection and they remain in breach of the regulations.

Allenbrook Nursing Home 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. Allenbrook Nursing Home accommodates up to 36 people in one building. There were 28 people living at the home at the time of our inspection.

A new manager had joined the service in February 2018 and had not yet registered. 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 told us they felt safe. However, further improvements were needed to ensure all people's risks were safely managed including people's equipment use and support with their medicines. Further improvements were required to ensure people would always be protected from the risk of abuse. We received mixed feedback around whether there were enough staff to meet people's needs and recruitment checks had not been carried out as planned.

People and relatives spoke positively about the care provided including meals offered. Staff showed awareness of people's health needs and told us they found training useful. People told us they were given choices and their consent was sought, although improvements identified at the last inspection relating to the Mental Capacity Act (2005) had not been fully addressed. We saw people could access healthcare services and the home was being supported to drive further improvements in this area.

People told us staff were kind and caring. Staff showed care for people, however this had not informed a consistently caring and respectful approach. We observed task-based care from some staff which did not

promote people's dignity and positive experiences. People were not always well engaged with and involved in their care as far as possible.

People did not all have good access to activities and things they may have enjoyed. Further improvements were planned to ensure care planning recognised and met all people's needs and preferences, including around end-of-life care. People and relatives felt able to complain and that this feedback would be used to improve their experiences.

Systems to assess, monitor and improve the quality and safety of the service were not effective. Concerns at our last inspection had not been fully addressed and the provider remained in breach of the regulations. There was a new manager and fully recruited staff and nursing team. People and relatives with generally expressed a positive experience of the service, although they felt there were not always enough staff or things to do. People were not engaged and involved in the service as far as possible to drive improvements and positive experiences of using the service.

You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

People's risks were not all effectively managed including medicines support and equipment use.

There were not enough staff to meet all people's needs.

Systems and processes were not always safe including recruitment processes, equipment checks and safeguarding processes.

People and relatives felt the service was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they were given choices and their consent was sought, although improvements identified at the last inspection relating to the Mental Capacity Act (2005) had not been fully addressed.

We saw people could access healthcare services and the home was being supported to drive further improvements in this area.

People's health needs were known to staff. People and relatives spoke positively about the care provided including meals offered.

Staff felt supported and received training relevant to their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always engaged well with and involved in their care as far as possible. This did not always promote people's dignity and positive experiences.

People told us staff were kind and caring and we saw some examples of positive interactions and rapport.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual preferences and wishes were not all captured through care planning processes, including for end of life care. Further improvements were planned.

People did not all have good access to activities and things they may have enjoyed.

People and relatives felt able to complain and that their concerns would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems to assess, monitor and improve the quality and safety of the service were not always effective and did not always ensure a person-centred, inclusive approach to people's care.

There was a new manager and fully recruited staff and nursing team.

People and relatives with generally expressed a positive experience of the service, although they felt there were not always enough staff or things to do.

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Detailed findings

Background to this inspection

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

This inspection took place on 27 and 29 June 2018 and was unannounced. The inspection was carried out by an inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was the care of older people. The specialist advisor was a nurse with a specialism in dementia care.

As part of our inspection planning, we referred to information and feedback shared by a local authority safeguarding team and commissioners of the service. We also checked whether any information was available from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We referred to other information we held about the service to help inform our inspection planning. This included notifications, which contain information about important events which the provider is required to send us by law. We also viewed monthly reports submitted by the provider, which they are required to send to us as part of our enforcement action from the last inspection in November 2017.

During our inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three people living at the home and eight visiting friends and relatives. We sampled records relating to nine people's care and recruitment files of three staff members at random. As part of our inspection we also spoke with three care staff, two nurses, a new clinical lead, a retired nurse who supported care planning at

the service, the manager, and three healthcare professionals involved with the home. We sampled other records relating to the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in November 2017, we rated this key question 'Inadequate' and identified two breaches of the regulations related to safeguarding and safe care and treatment. At this inspection, we found some improvements had been made, however further improvements were required. The provider was still in breach due to concerns around safe care and treatment because some people's risks were not safely managed which included the management of medicines. The provider had developed their safeguarding systems however they had still not met this breach because those systems were not always effective. This inspection found there were not enough staff to meet all people's needs and improvements were required to recruitment checks and health and safety checks. We have rated this key question 'Requires improvement'.

People and relatives told us they felt the service was safe. One person told us, "I feel safe here, the staff make me feel safe." Another person told us, "From the way [my relative is] looked after and cared for, I'd say they are safe." Since our last inspection, some improvements had been made to how people's risks were managed. Staff showed an understanding of people's risks and needs, and the manager had arranged further staff training to promote safer practice for example when staff supported people to move using hoists and if some people became distressed. We found improvements to how people's wound care and catheter care was documented and we saw people's risk assessments were regularly updated. The manager had ordered some new equipment such as mattresses for people to help prevent pressure areas, although we were told equipment was not available for one person to use safely on their short stay at the home.

However, some of our observations found people did not always receive their medicines safely and as prescribed, although people told us they were satisfied with this aspect of their care. One person told us, "I rely on [the nurses]. I don't have to worry. It's always on time and I've not missed any." Although stock levels we checked for three people's medicines matched with their medicine administration records (MARs), we observed that a new nurse did not complete those records as they supported some people with their medicines, and asked care staff to give some people their medicines on their behalf. This meant the nurse did not effectively monitor that people received the right medicines and that records accurately reflected this. On one occasion, we saw two tablets were left on top of a medicines trolley in a communal area where people ate nearby. This posed the risk that the right person may have not been given their medicines, and someone else could have taken them in error. We asked the manager to try to find out what the medicines were and who they belonged to because this was not clear. In another example, people's medicines to help manage a healthcare condition were not given safely. One person was given the incorrect amount of insulin prescribed, based on another person's blood glucose levels. The nurse had not checked the person's own blood glucose levels and had referred to another person's checks in error. People were not all kept safe through the proper and safe management of medicines. The manager told us the nurse would be given further guidance and support to ensure people would always be supported safely. There was a designated storage area for medicines however some items were not safely stored. Some people's prescribed drinks were all stored together and not always labelled. A nurse told us, "Those not labelled, I'll know whose they are."

Improvements were still required around how some people's risks were managed. Some recommended actions were not known or followed by staff to help keep one person safe and reduce further incidents of attempted self-harm. For example, recommendations to closely monitor the person or encourage them to use of specific equipment had been recorded but this had not been implemented. Risk assessments did not always set out how to support people effectively in light of identified risks.

The provider had not ensured all equipment used was safe. Another person had their own suction machine however no risk assessments were in place to help monitor its safety and suitability. Safety checks had not identified that the home's own suction machine had not been serviced since April 2016. We observed and staff told us they could not apply the brakes on two wheelchairs due to faults. They had reported this previously due to concerns that people would not be supported safely, however it had not been addressed. The manager removed this equipment during our visit.

The provider failed to provide safe care and treatment and mitigate risks to people using the service. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we identified a breach of the regulations because systems to respond to safety incidents and safeguarding concerns failed to protect people from abuse or harm. Since our last inspection, systems had been developed and some incidents such as falls and bruises, were monitored more effectively. Staff had received safeguarding guidance since our last inspection, and followed their role to record and report such incidents, which had led to referrals being made to relevant partner agencies by the manager. However, those systems were not always effective because the provider and manager had not identified and responded to all safeguarding concerns appropriately following their review of incidents, including one person's self-neglect. We prompted the manager to make safeguarding alerts to the local authority for incidents involving two people. Improvements were still required to the systems and processes in place to help safeguard people from abuse.

The provider failed to operate effective safeguarding systems and processes. This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us they had explored with staff whether more staff were required, and staff confirmed to us they felt there were enough staff to support people safely. We saw staff were visible but often busy involved in care tasks and as at our last inspection, staff were not always available to spend time with people outside of this. Some people and visitors told us more staff were needed at times, although they felt staff worked hard. For example, one person told us, "They can be short staffed at times. I wish there was more opportunity for me to go to the toilet. I have a sore bottom as I have been sitting on a wet pad. The staff are so busy they can't always see to me." A visitor commented, "Staff take a long time to come, people get stressed." Another relative told us, "I really don't think there are enough staff to watch people and go to [person cared for in room]." Some people spent time in the conservatory and we observed staff did not often go to check people were okay. Some people dropped items or called out for staff unnoticed nearby. Staffing arrangements did not ensure all people's needs were met in a timely way.

Three staff files we sampled at random showed adequate recruitment checks had not been carried out. Staff had completed checks through the Disclosure and Barring Service (DBS) before they started in their roles, however none of the staff files showed reference checks had been completed as planned. The provider had not completed reference checks for two staff, and had only gathered one reference for the third staff member. We brought this to the manager's attention. Recruitment checks had not always been carried out as planned to ensure people were supported by suitable staff.

Fire safety checks were carried out regularly to help staff understand how to respond in the event of a fire. Other health and safety checks were in place to reduce risks posed by the environment and domestic staff helped maintain the home's cleanliness. People and visitors told us the home was clean as we observed. The manager intended to introduce an infection control lead role and further develop health and safety audits to improve the safety of the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2017, we rated this key question 'Requires improvement'. This was because people's care needs were not assessed and monitored effectively with prompt access to further healthcare support as needed. People were not always supported in line with current good practice guidelines and the principles of the Mental Capacity Act (2005). At this inspection we found improvements were still required in those areas and we have rated this key question, 'Requires improvement' again.

At our last inspection, we found people's needs were not always monitored and responded to effectively to help promote good health outcomes. At this inspection, we saw improvements had been made to how people's needs were monitored. People's care records were regularly updated and reflected their current needs, although this information was not always personalised. We saw referrals had been made to other healthcare professionals such as dieticians and tissue viability nurses, in response to people's changing needs to help promote their health. A doctor was called to visit one person due to concerns about their health. Another visiting healthcare professional told us, "I feel people are well kempt and looked after. Any concerns [and recommendations] are dealt with. Staff very friendly and know people well."
Further improvements were planned in this area with support set up by the local authority, to help reduce how often people went to hospital on occasions where this could have been prevented. At the time of our inspection, an advanced nurse practitioner had started to visit the home each week. Some feedback we received suggested information was not always shared effectively between staff to ensure people could be supported in a timely way when healthcare professionals visited. Nurses had since been encouraged to clearly record such information as well as to take more ownership when people's needs and symptoms changed, prior to contacting emergency services. This initiative was in the early stages and intended to further support the nursing and care staff to help meet all people's needs effectively.

At our last inspection, we found the needs of people living with dementia were not always met in line with current good practice guidelines and through the design and décor of the home. This area of improvement had not been fully addressed. The new manager described their plans and possible ways to help engage and promote the independence of people living with dementia at the home, to start to address this. As at our last inspection, we found signage and pictorial information had not been considered to help navigate people around the home. We saw most people remained sat in lounge chairs for their meals and had their food brought to them. This was a missed opportunity to involve people further for example to socialise and eat together. We saw some people could not reach their food with ease due to the positioning of their lounge chairs and pull-up tables. Staff did not always identify this and ensure people were supported to sit more comfortably or have easy access to their meal. Some further needs had been brought to the provider's attention to promote people's comfort and accessibility for example to take a bath. Further improvements were required to ensure the design and décor of the home were developed around people's needs and preferences.

The Mental Capacity Act (2005) 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 told us staff always asked for their permission before providing them with support. We saw people were involved and supported with basic decisions about their care and a staff member gave examples of helping one person choose what to wear by showing them options. Visitors told us told staff always explained to people what they were going to do when they supported them as we observed. Staff had received refresher training and showed a basic understanding of the MCA.

However, areas of improvement identified at our last inspection in relation to the Mental Capacity Act (2005) had not been fully addressed. People's care plans had been updated and contained general information about the MCA, but did not always show how a person could be supported to understand and make their own decisions as far as possible.
Other documentation relating to decisions about people's care had not been effectively monitored and reviewed. 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 authorisation 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 provider had not maintained a record of previous DoLS applications made and it was not clear whether these had been assessed or authorised. In another example, one person's record inaccurately suggested they had a DoLS authorisation in place and did not provide personalised information about how to promote the person's safety and independence. Staff were not always aware of who had a DoLS authorisation in place and what this might have meant for people. The manager had made applications for other people more recently and tracked the progress of these and told us they would provide more guidance for staff. At our last inspection, we were told restrictions such as door codes and gates were in place due to historic risks. The provider had told us they would assess whether those restrictions were still necessary to ensure people's safety. The provider had not done this and ensured systems were in place to promote all people's rights and choices as far as possible.

People and relatives felt that staff worked hard and were good at supporting people. A relative told us, "Staff are good with [person]." Another relative commented that another person was well supported by staff. Staff were aware of people's specific risks and health needs, and shared this information through daily information sheets and handovers together.

Staff told us they felt supported in their roles. A staff member who had recently joined told us they had received an induction and could speak to colleagues or the manager if unsure. The staff member had been informed of people's health needs and how to help keep people safe. Training from external providers had been planned around staff learning needs. For example, the manager told us they had found improvements to how people were supported after more moving and handling training had been provided to staff. We saw people were supported with care and at a pace that suited them when using the hoist. Staff spoke positively about the training provided, including to help them respond effectively when some people became distressed. One staff member commented, "We try and talk, do more talking and explaining. Sometimes I don't think we realise what it is like for them [the person], the training was so helpful." Additional training was available to staff for example related to catheter care and person-centred care. The manager also intended to improve the induction process based on staff feedback they had received, and ensure the Care Certificate was offered to staff new to care. The Care Certificate is a set of minimum care standards that new care staff must cover as part of their induction process. Staff were supported and received the training needed for their roles.

People and relatives spoke positively about the food on offer. The food looked appetising and people told us they were always given choices. One visitor told us, "The food is very good and looks nice. I've had a few

dinners here and it is nice." We saw that people were regularly offered drinks. People's food and fluid intakes were monitored along with their weights, and some people had been prescribed supplements to help them reach a healthier weight. A senior staff member described how this was monitored and we saw staff shared information about who needed support and encouragement to eat. Although people's special requirements for their meals and drinks were known to staff, kitchen records related to this were not always updated and an agency chef did not have clear oversight of people's risks.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2017, we rated this key question 'Requires improvement'. This was because people experienced task-based care and were not always well engaged with. At this inspection we found these concerns had not been fully addressed to ensure people received a consistently caring service. We have rated this key question, 'Requires improvement' again.

At our last inspection, we found staff did not spend time with people outside of care tasks and some people were not often interacted with. At this inspection, we found this area of improvement had not been fully addressed. Staff showed care for, and awareness of people's preferences and health needs, however this had not informed a consistently caring and respectful approach for each person's needs and preferences.

We observed that people were not all supported to engage or spend time doing things they might have enjoyed, and they were not often approached by staff. One person commented to another, "There's no [staff] here today is there", and the person responded that staff had been helping people with personal care tasks. In another example, as we had observed at our last inspection, one person spent most of their day in the same chair and watched what happened around them, with nothing to do. We saw an effective approach from one staff member when they supported this person to eat. They talked about the taste of the food and how the person enjoyed this and the person responded well.
However, we some staff often focused on the task they were doing when they supported people, and did not all use these opportunities to chat to people and build up good rapport. For example, although staff were careful in their approach and checked people were safe, we saw some staff spoke only to check if people had swallowed their food each time so the person could then be supported to have another mouthful of food. Some staff provided only limited instructions during care tasks and did not make conversation with people otherwise. Staff were respectful in their approach however did not always promote a positive experience for people with meaningful opportunities to socialise.

We identified some use of language by staff, the manager and in records which did not reflect and promote a consistently caring culture. For example, staff and records referred to "toileting" and "feeding" people, which did not promote people's dignity as individuals and instead referred to care tasks. A relative told us, "[Person] has to wait to go to the toilet. [Person] puts their hand up but is kept waiting." We overheard one staff member tell another person, "You can't toilet people and put them to bed at the same time," because the staff member was busy supporting someone else when the person had asked for their support. It was not appropriate to use this language to the person and the staff member did not respond kindly to the person's request for help. This approach meant people were not always treated with respect and to have their dignity promoted. The staff member later told us they hadn't meant to be offensive to the person and showed they had reflected on this.

Improvements were still required to ensure people could be actively involved in care discussions and decisions as far as possible. People and relatives told us they were not involved in regular care plan reviews, although relatives told us they were updated on how people were. The manager had previously introduced 'Resident of the day' as a means to regularly involve people in care reviews and to help staff learn more

about people. This had not carried on and the manager told us it was, "Something we've got to get back on board again now." A staff member told us, "I haven't seen care reviews but we do ask if people are okay." Care records we sampled did not demonstrate that people's views and wishes had been gathered and used to inform their care planning as far as possible.

People told us staff were kind and caring. One resident told me, "Staff always have a smile and are very kind". Another person told us, "The place is comfortable." We saw people could decorate their rooms as they wished and they were kept to a clean standard. Some staff members had a clear caring approach and we saw they often smiled and talked kindly with people. One person told us, "Staff are very good, very kind." A relative told us, "Staff are always polite."

We overheard that staff reassured one person as they supported them with personal care. A relative commented, "They are very good at doing that, for example, they will say, "We are going to the bathroom now."' We saw positive interactions between some people with others living at the home and staff. One person told us, "I have other people around me. I was lonely before but not anymore." People were all in clean clothes and well groomed, and we saw staff made efforts to promote their dignity for example using blankets to help cover and comfort people when they were hoisted. Staff described other ways they helped promote people's dignity during personal care.

Residents' and relatives' meetings had been arranged to help people and relatives to ask questions and share their views on the home. We saw the manager had made expectations clear to staff about providing person-centred care, and they had provided people and relatives with updates about their plans at the home. A recent family and visitor survey showed respondents had commented positively on the atmosphere of the home and the approach of staff. One respondent had stated, "Some members of staff go beyond their job". The manager had started to drive improvements to promote a consistently caring culture.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2017, we rated this key question 'Requires improvement' and identified a breach of the regulations because people did not receive person-centred care. Staff did not have access to current information about people's needs and wishes, including around end of life care. Our last inspection had also found complaints had not been effectively addressed and responded to. At this inspection, we found some improvements had been made and the previous breach of regulation had been met. However improvements were still required in those areas and we have rated this key question 'Requires improvement' again.

At our last inspection, we found people did not all have good access to activities and things they may have enjoyed. At this inspection, we found this had not been fully addressed. A newsletter we viewed and discussions with staff showed people had enjoyed calendar events and activities at the home including animal visits and Christmas celebrations. Staff spoke positively about this and referred to an individual staff member who dressed up and went the extra mile to create memorable occasions for people and staff. However, during our inspection, we found alternative plans had not been made in the activity coordinator's recent absence to ensure people all had consistent and good access to activities. Some people commented there was little to do and visitors told us staff did not always have time to spend with people. One relative told us, "Activities have been lacking for some time. Staff will sometimes sort out some activities, but can't do as much as the activities co-ordinator." Outside of care tasks, we observed limited interaction between people and staff, and saw people spent time sat in communal areas with little to do. We asked one staff member if people could access the garden for example and spend time with staff there. The staff member replied, "Obviously we don't have the time and we've got toileting to do, one staff member couldn't sit out there." Some people who were more independent read newspapers brought in by relatives or played games as they wished. They told us they watched television, played bingo or talked to others as activities to pass their time. People did not have consistently good access to activities. The manager told us this was a priority area of improvement.

After our last inspection, the provider recruited a nurse to support staff with person-centred care planning. At this inspection, we saw that these records had been updated and were regularly reviewed to help monitor people's support. Staff showed awareness of people's health needs and risks and we saw some positive examples of how people were supported as individuals, for example a staff member tailored their approach to each person to help engage and involve them. One staff member told us staff helped meet a person's communication needs effectively, and that they asked one person to write down their requests until they also became familiar with the person and understood the person as well as other staff did. Some people confirmed they attended a church service which was held regularly at the home.
Further improvements were required however to ensure care planning processes always explored and met people's needs and wishes as far as possible. People told us they were not routinely involved in discussions about their care, although relatives told us they had some input. A staff member was keyworker to one person and could tell us the person's health care needs and ways they needed to be supported. When we asked if they knew about the person as an individual, for example, the person's life before moving to the home, the staff member told us, 'Not really no', although they could tell us such detail about another

person. This meant that the keyworker system had not always helped the person to be well known to the staff member and to have their identities and preferences understood. Some people who stayed at the service for a short period of time were inappropriately referred to by staff as "bed blockers". The manager commented, "They're on the block bed so we don't get to know them well." This did not reflect a culture which promoted achieving person-centred care for every individual.
Care plans we sampled were not always complete and personalised and showed little evidence of people's own voice and wishes. For example, information was not available about one person's needs related to diabetes and for another person being cared for in bed. Information such as a person's chosen religion and first language had been recorded, however such needs had not been explored in more details or for additional ways to support the person accordingly. The nurse and manager told us they had plans to refer to current good practice to help personalise people's care plans, for example through reference to 'This is me' guidance, and the manager told us they promoted a person-centred approach to staff during supervisions and team meetings.

At our last inspection, information had not been gathered to ensure people's wishes for end of life care would always be known and met. At this inspection, we saw improvements in this area and people's care plans had been updated about this aspect of their care. However, this information was not always personalised. For example, one person had been previously considered by a doctor as approaching end-of-life. Pain relief medicines had been made available this person to help promote their comfort, however their care records contained generic statements and did not show their wishes had been gathered and explored further. A nurse involved in developing people's care plans told us they would address this as part of ongoing improvements.
There were end-of-life champions in place to help promote good practice in this area although nobody required this level of support at the time of our inspection. One staff member told us that as part of this role, they had worked closely with a local hospice and healthcare professional to further their knowledge. The staff member described the importance of prompt contact with a doctor when people's conditions changed, to ensure their care needs were met.

At our last inspection, we found complaints were not effectively addressed and responded to, to help drive forward improvements at the service. At this inspection, we saw a complaint from January 2018 had been logged and addressed appropriately. The manager told us no other complaints had been received since they had joined. People told us they had no complaints about the home, but they felt able to tell staff if they did have any concerns. People told us they felt their concerns and complaints would be acted upon. One person commented, "I haven't any complaints, but if I did I would tell my relative who would be on to it straight away." Two people told us they were satisfied with how their previous complaints had been dealt with. People and relatives felt able to raise concerns and confident these would be addressed. Complaints were looked at as part of the manager's regular audits so any complaints received could be used to improve the service.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2017, we rated this key question 'Requires improvement' and identified two breaches of the regulations. This was because poor systems and processes had failed to ensure the safety and quality of the service and the provider had failed to notify the Commission of relevant events and incidents at the home. After our last inspection, we took enforcement action to impose conditions on the provider's registration which required them to submit monthly reports to the Commission due to our concerns. The provider met this condition and provided information as requested. However, at this inspection, we found the improvements identified at our last inspection had not been fully addressed and neither breach of the regulations had been met. We have rated this key question, ''Requires improvement' for a fourth time.

Systems and processes had been developed since our last inspection to assess, monitor and improve the safety of the service, however these were not always effective. Quality audits had not effectively assessed, monitored and improved the quality of people's experiences, including that staff were not often available to engage with people outside of care tasks. As at our last inspection, people were not all supported to do things of interest they might have enjoyed and plans had not been made in the absence of an activity coordinator to help address this. Systems introduced such as 'resident of the day' had not been sustained or embedded in practice to involve people in their care as far as possible.

Systems and processes did not always ensure the safety of the service. Health and safety checks had been carried out, however had failed to promptly identify and address safety issues we found on inspection to ensure people used safe equipment. Staff told us they had previously reported faults on two wheelchairs, however this had not been actioned. Staff continued to use the wheelchairs to support people but did so less safely to accommodate the equipment faults. We also found that a shower room people used had a strong, stale and musty smell. The shower chair had not been maintained and the shower grill was broken, rusty and not fitted safely. When we brought these concerns to the manager's attention, the issues were then addressed to reduce those risks to people.

In another example, the manager's medicines audits had identified recording errors such as incorrect stock counts, however there was no record of what had been done to reduce similar errors in future and ensure people had received their medicines as prescribed on those occasions. The manager was in the process of addressing some recommended improvements following a pharmacy audit in March 2018 and had developed a more detailed audit to use moving forward, to help promote safe and consistent medicines management.

Other improvements identified at our last inspection had not been fully addressed and sustained to ensure the quality and safety of the service. For example, after our last inspection, the provider described plans to help develop staff awareness about safeguarding processes, however we found staff were still not all aware of how to report concerns outside of the home if needed, for example to the Care Quality Commission or to the local authority. Since our last inspection, we saw improvements to how incidents were recorded by staff and the provider had introduced systems to review this information and identify any further action to be

taken. However, these systems were not always effective and this had not been identified by the provider. The manager was aware of incidents, but had not always documented their reviews and action taken to keep people safe, and we found incidents involving two people had not been identified as safeguarding concerns by the manager as necessary to help protect people.

The provider did not have effective systems and processes to assess, monitor and improve the safety of the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have required the provider to continue to submit monthly reports to the Commission as per the conditions imposed on their registration after our last inspection.

At our last inspection, we identified a breach of the regulations because the provider had failed to notify us of specific events and incidents. Since the inspection, systems had been developed to review and share information about incidents with relevant partner agencies including the Commission. The Commission had not been notified as necessary about some incidents to help protect people living at the home and the provider's systems had failed to identify this. We prompted the manager to take this action.

This was a repeated breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is finalised.

Since our last inspection, a new manager had joined in February 2018. People told us the manager was visible and approachable. One person commented, "The manager is approachable, best one we've had for a long time." The manager told us that since joining, they had focused on developing a more stable staff team and that a recently fully recruited nursing team would help improve the consistency of people's care. Staff spoke positively about their roles. We saw training courses were offered and a home newsletter celebrated two staff members' progression in their roles. Staff had completed surveys in March 2018 about their experiences at the home which the manager told us they intended to use to help identify other areas of strength and improvement. The manager had not yet fully analysed this feedback but had made plans to improve the staff induction process in response to some feedback received.

The manager also completed their own audits and submitted a summary of quality assurance activities to the Commission as part of our enforcement work carried out at the last inspection. They had recognised learning was required for some staff around providing person-centred care as further ways to drive improvements at the home. Commissioners had continued to work closely with the home and told us they had noted improvements in recent months and since our last inspection. A new clinical lead had recently joined and the manager told us they anticipated this additional leadership role could give them opportunity to work through priority areas of improvement together. Our discussions with the manager showed their awareness of current good guidance and their plans to introduce their use alongside other developments at the home to continue to improve people's experiences.

People and relatives we spoke with generally expressed a positive experience of the service and told us staff worked hard. The areas of improvement they referred to were of a lack of staff availability and not enough for people to do. One person told us, "The place is comfortable, the food is brilliant, there isn't enough going on here. We do have a church service regularly." A visitor told us, "Staff are always welcoming. They offer me tea or a sandwich whenever I come." Relatives were encouraged to visit often and got involved in aspects of people's care, however this had not been included in people's care planning to ensure this support always promoted people's safety and wellbeing.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide safe care and treatment and mitigate risks to people using the service. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to operate effective safeguarding systems and processes. This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes to assess, monitor and improve the safety of the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have required the provider to continue to submit monthly reports to the Commission as per the conditions imposed on their registration after our last inspection in November 2017.