Dwell Limited

Long Lea Residential Home

Inspection report

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Date of inspection visit:
20 September 2016

Date of publication:
14 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 September 2016 and it was unannounced.

Long Lea residential home is one of two services provided by Dwell Limited and provides accommodation and personal care for up to 35 older people; over two floors. At the time of the inspection 35 people lived at the home. Long Lea was last inspected by us in October 2015 and we found a breach in the regulation relating to the safe management of medicines. We gave the home an overall rating of 'requires improvement.'

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post, who is the owner / provider of this service. The registered manager splits their time between this home and their domiciliary care service.

People had not always received their medicines as prescribed because staff could either not find them or stock had run out because staff had not ensured there was enough. Guidance was not available for staff to refer to in order to ensure people received 'when required' medicines or prescribed creams in a safe way.

People felt safe living at the home because staff were there to support them when needed. Staff were trained to know what abuse was and how to report any concerns to the registered manager.

Some risks to people's health and welfare were assessed but actions were not always put into place to reduce the risk of harm or injury to people. Some risks were not assessed and staff did not have the information available to refer to, if needed, to know how to keep people safe.

Staff worked within the principles of the Mental Capacity Act 2005 when supporting people with personal care. People had choices offered to them about what they wanted to eat and drink and were supported to maintain their health and see a GP, for example, if they felt unwell.

Staff had received training and felt this gave them the skills and knowledge they needed to meet people's needs effectively. Staff promoted people's privacy when they were supported with personal care.

People said staff were, overall, kind to them and involved them in making decisions about their day to day care and how they spent their time. There were planned group activities for people to take part in if they wished to do so and people told us they enjoyed the activities.

Systems were in place to assess the quality of the service provided but audits were not always effective and improvement was not implemented when needed. Risks associated with the management of medicines and

risk of cross infection had not been identified by checks undertaken. Care plan reviews had not identified where improvement was needed.

We found breaches of the regulations relating to the safe management of medicines, the safe care and treatment of people and the governance of the home. 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 consistently safe.

People did not always receive their medicines as prescribed and guidance was not always available for staff to ensure people received their medicines in a safe way. Some risks associated with people's care were assessed, however, actions were not always put into place to reduce the risk of harm and some risks were not assessed.

People felt safe living at the home because staff were there to support them. Staff were trained to know what abuse was and how to report any concerns to the registered manager.

Is the service effective?

Good

The service was effective.

Staff had undertaken training to deliver care and support to people. Staff worked within the principles of the Mental Capacity Act 2005 when supporting people with personal care. The requirements of the Deprivation of Liberty Safeguards were followed. People were offered choices and enjoyed the food and their nutritional needs were met. People were supported to maintain their health and were referred to health professionals.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff were kind and caring towards them or their family member. People were involved in decisions about their day to day care. People's privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People felt that overall their care needs were met by staff, however we observed a few people's needs were either not met or not met in a sensitive way. There were planned group

activities for people to take part in if they wished to do so, which people said they enjoyed. Feedback was sought from people and was due to be acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had some systems in place to monitor the quality of the service provided but had not ensured these were effective. This meant opportunities to identify where action was required to implement improvement were missed. Staff told us they felt supported by the registered manager.

Long Lea Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 20 September 2016 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and an 'expert by experience.' An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

The provider had previously completed a provider information return (PIR). Prior to this inspection, a request for a new PIR was not made. During our inspection, we gave the provider an opportunity to supply us with key information, which we then took into account during our inspection visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke with 21people who lived at the home and 6 relatives or friends, who told us about their experiences of using the service. We spoke with staff on duty including six care staff, two cleaning staff, the cook, the activities staff member and the registered provider. We spent time with and observed care staff offering care and support in communal areas of the home.

We reviewed a range of records, these included nine care records and nine medicine administration records (MAR). We looked at quality assurance audits and feedback sought from people.

Requires Improvement

Is the service safe?

Our findings

At our inspection in October 2015, we identified a breach in the regulations regarding the safe management of medicines. We found people were not protected against the risks associated with the unsafe use and management of medicines. For example, dosages of 'when required' medicines, including a controlled drug, were not recorded and detailed records of people's medicines were not kept by staff which meant stock ran out. We told the provider improvement was needed. At this inspection, the registered manager told us they had implemented improvements. However, we found these were not sufficient and people were not protected against the risks associated with the unsafe use and management of medicines. This was a continued breach of the regulation.

People were not always given their medicines as prescribed. We identified six people had missed dosages of some of their medicine in the last month (August 2016). For example, one person missed 20 days of one of their medicines that staff should have given to them on a daily basis. We found this person's medicine was not in the medicine trolley but in a container to be returned to the pharmacy for disposal. On the day of our inspection visit, we identified two people whose medicine had run out. A staff member told us they had requested more stock. However, we found that the provider's management of medicines had not ensured there was sufficient stock available for people to be given their medicines as prescribed. This meant people were not always receiving medicines as part of their treatment and this had a potential impact on their health and wellbeing.

Some people had medicine prescribed that was to be taken 'when required'. These included medicine such as paracetamol, other very strong pain relieving medicine and some medicines used to manage anxiety and behaviours that might be challenging. We found there was no information available for staff to refer to on when people's 'when required' medicine should be given to them. We discussed this with staff and one staff member told us, "People are able to verbally tell us when they need it." However, some people were living with dementia, some people did not communicate verbally and where medicines were prescribed for anxiety, people may not recognise themselves when they required their medicine. This meant improvement had not been made since our last inspection, and staff did not have information to refer to so that people were given their medicines in a safe and consistent way.

We identified three people were being given their 'when required' medicine on a daily basis. Staff told us their medicine was used to 'control their behaviour,' however, these medicines were prescribed only to be given when necessary. We found no guidance or care plan to advise staff when these people's medicines should be given. We discussed this with staff but they were unable to show us any record or tell us why these three people were being given their 'when required' medicine every day. We found there had been no request made to the GP to discuss or review the use of these people's medicines. The registered manager told us that they thought one person "was addicted" but they had not asked for a GP to review this person and the use of their medicine.

Some people were prescribed topical items such as creams. We asked one senior staff member why there were no staff signatures on people's medicine administration record to say when creams, for example, had

been applied. This staff member told us that people living at the home applied their own creams, however another staff member told us only two people would be able to do this properly. We asked a staff member if they applied creams to people and they told us, "I'd always help people with their creams if they asked for help or if I thought they needed some applying." Staff informed us that they did not routinely record when they applied creams to people, one staff member said, "I think some carers might put in as part of the daily notes but there is no chart to complete."

One person's MAR showed a prescribed cream that should be applied twice a day. However, we saw that this cream had not been used for over a month and the tube was still sealed. We discussed this with the registered manager and they told us they believed this person no longer needed the cream. However, we found no review of this had been requested with this person's GP.

Staff told us they had been trained to safely handle and administer people's medicines but we found this was not always effective because staff did not always follow this or the provider's medication policy. For example, medicines that had a short expiry date once opened were not always dated by staff to ensure they knew how long the medicines could safely be used for.

This was a continued breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some assessments were in place to identify where people were at risk but these did not record actions to be taken, by staff, to minimise the identified risks. For example, one person had been assessed as being at risk when mobilising and their risk assessment documented that this person 'often mobilises without help'. However, there were no actions linked to this to advise staff on how they could minimise the risk of falls but only a general note to say the support required was 'a zimmer frame and one carer.'

Some risks had not been assessed. For example, one person told us, "I was given some cream and I put this on myself. I had a painful neck and I put some cream on, it relaxed the muscles too much and I had difficulty swallowing." One staff member showed us a tube of over the counter 'deep heat rub' in this person's bedroom and told us, "I think [Person's name] uses this on their knees when they get painful." We found no risk assessment recorded in relation to this person self-medicating, or in relation to the use of 'deep heat' or any other medicines. Their care record said they had 'medication administered by staff'. We discussed this with the registered manager and they told us they were unaware of this person having the 'deep heat rub' or who had given it to this person. Following our inspection visit, the registered manager informed us they had completed a risk assessment for this person.

We saw one person had bed rails (sometimes referred to as cot sides) attached to the sides of their bed. However, this person told us, "I am perfectly safe in bed and don't need them." This person confirmed to us that staff did not pull up the bed rails at night but they had to slide over part of one bed rail to get in and out of bed. This person's care record showed that in March and April 2016, the bed rails had been used because staff felt it would be 'safer' for this person. In May 2016, records showed this person had requested them not to be used and staff had documented the bed rails had been removed. We found this had not been done, because they were still attached to this person's bed, one bed rail had part of its metal frame in line next to this person's pillow and this, coupled with this person having to slide over the rest of the bed rail, presented a risk of potential entrapment and injury to their skin. Following our feedback to the registered manager they told us these bed rails would be removed.

Some people had been assessed as 'at risk' of developing sore skin or pressure ulcers. One person's care record described them as at 'high risk' and measures to reduce this risk were for 'carers to check skin daily'.

Staff had recorded an area of 'broken skin, red area' on 2 September 2016 and a further 'sore' on 3 September 2016. However, we found no care plan to inform staff when and what to check. We found no further reference to this person's sore skin in their care records and asked staff about this. One staff member informed us this person had a separate district nurse file, which had one entry on 2 September 2016 recording the 'sore' was observed and noted a special mattress order had been made. The special mattress had arrived at the home on 7 September 2016 but we saw it was not being used on this person's bed, we discussed this with a team leader, who said they were unaware the special mattress had been recommended or ordered and believed this person would not want to use a special mattress. Another staff member told us, "This person refuses personal care from us during the day so we can't check their skin. It would be the night staff that do this." Care records said 'all checks' had been completed, however there was no detail on what had been checked and findings from these checks. We found identified risks of people developing sore skin were not managed effectively.

Most people told us staff gave them their call bells when they were in their bedrooms so they could gain staff attention if needed, for example to safely walk to the ensuite toilet. We spoke with three people in their bedrooms and of these, two had their call bells accessible to them. We saw one person's call bell was not within their reach, this person told us, "Staff did not give me that (call bell)." We informed a team leader about this at 1pm and they told us, "They should have it close to them, I'll mention it to a carer." At 4.30pm, we went to check if this person had their call bell but saw it was in the same place and out of reach. This meant this person was unable to gain staff attention if needed and throughout the shift staff had not ensured this person had their call bell. This person had previously been described to us by the registered manager as a 'frequent faller' and as part of their falls prevention they should be given their call bell so they could gain staff support when needed, so that their safety was maintained.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, people told us they felt safe living at the home. Staff had received training in how to safeguard people from harm and abuse, and knew what to look out for to keep people safe. One staff member told us, "Someone might be withdrawn, have a change in mood, have marks on their body." Staff knew the action they should take if they were concerned someone might have experienced abuse, harm or neglect. One staff member told us, "I would document things and ask the staff member to write a statement. If I felt there was a risk I would report it to the manager. If I was still worried after that I would phone CQC or the local authority."

Staff told us they had to wait for references and criminal record checks to be returned before they started work. This meant that the provider took steps to ensure staff were of good character before they cared for people living at the home.

People told us there were enough staff on shift to keep them safe. One relative told us, "I am quite impressed with the staffing levels here. There always seem to be staff about." Staff told us they felt there were always enough staff and they had time to interact with people and not just help with basic day to day needs. One staff member told us, "We never use any agency staff here, but we'll cover for one another if needed. The manager makes sure there are enough staff on."

We asked staff how they would deal with emergencies, such as a fire or accidents that might arise from time to time. One staff member explained what action they would take in the event of a fire and told us there were fire doors at the home and said, "These give us thirty minutes. It is the same with bedroom doors. If we felt we had time to hoist people we would if we needed to move them to a safe area. We also have the

evacuation mat upstairs if needed." Staff said they would call 999 if they needed professional help if a person had a fall, for example. This meant staff knew when to seek professional healthcare support.

Good

Is the service effective?

Our findings

People felt staff had the skills they needed to support them effectively. One person told us, "I can't fault the staff, they are very good. They know what they are doing."

One recently recruited staff member told us they had been given basic training when they started including moving and handling; first aid; mental capacity and safeguarding. They told us they felt well supported and were given the opportunity to say how confident they felt.

One staff member told us, "Most of the staff have worked here for some time, so have got to know people well." Staff told us they were supported to access basic training to help them meet people's health and safety needs. They also told us they had access to more specialist training so they could develop their skills and support people better, as well as for their personal development. One staff member told us, "I am half way through a level five diploma at the moment. It is giving me more information and ideas about keeping the team happy and dealing with conflict."

Staff told us they were supported to access training relevant to their role. One staff member told us "I have just done a level 2 diploma in activity leadership. One of things I learnt was about exercise and how important it was. I was observed doing that twice by the assessor during the course, and I now do exercises twice a week with people." Another staff member said, "I have been able to do a team leading course through a local college. It helped me learn how to lead a team and with communication." A further staff member told us about training they had received on how to support people to de-escalate behaviour that could be challenging. They said, "Because we have a few people who can be quite demanding, you can think about trying diversions with people."

Staff told us they had individual meetings with senior staff on a regular basis. One staff member said, "We talk about strengths, weaknesses, if you are happy in your job, that kind of thing."
Staff told us their experience of having their practice assessed on an on-going basis. They said they were observed via 'spot checks' six times a year, and that the checks would focus on different areas of work each time. They told us one could be in relation to medicines, whilst the next could focus on moving and handling of people. They commented, "They write up their feedback, we discuss it and we sign it."

Staff understood the importance of gaining people's consent before undertaking personal care tasks and had some understanding of the Mental Capacity Act, though not all were sure if they had received training on it. Staff told us if they were unsure they would talk to senior staff about what they should do. Talking about their understanding of capacity, one staff member said, "Some people have capacity, but not all. Families can help with making some decisions. For bigger decisions, we would document things in the care plan and get advice from other staff members and go to the manager." Another staff member said, "If there was a big decision to be made and the person lacked capacity, I would discuss it with the registered manager."

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.

The registered manager informed us that one person was deprived of their liberty and they had submitted a referral for this person. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

People told us they enjoyed their meals. One person said, "We have choices and the food is always hot when served. I enjoy it." One relative told us, "My family member says that the food is lovely." Over lunch, we saw staff encouraging and ensuring people had enough to eat. For example, one staff member said, "Would anyone else like some more mashed potatoes?" People had drinks accessible to them throughout the day of our inspection visit and were also frequently offered hot drinks and snacks.

People had Malnutrition Universal Screening Tool (MUST) assessments. (MUST) is a management plan for people who are malnourished or at risk of malnutrition. We spoke with the cook and they told us they added extra calories to all meals, such as cream to porridge and high calorie snacks, such as full fat yogurts or cheese, were made available to people in between meals. Staff recorded details about people's food and fluid when needed, so that their intake could be monitored and checks were made on people's weight.

People told us they saw the GP if they felt unwell and care records showed people were supported to access health professionals such as opticians, chiropodists and dentists. Care records showed medical support was sought by staff when people were unwell and people had also recently been supported to have seasonal flu vaccinations.

Good

Is the service caring?

Our findings

People told us they felt staff were generally kind and had a caring approach. One person said, "I've got no complaints about the staff, they are kind and friendly to me." Another person said, "I feel very well cared for here. I've got a particular worry at the moment about something outside of this home, but the manager has been supportive and caring, they have bent over backwards for me."

We asked staff how they encouraged and promoted a caring atmosphere, one staff member said, "It is a family home. We like people to feel they can trust us. We just come here as guests in their own home." Another staff member spoke about how they thought people felt living in the home. They commented, "A lot of the people say they are happy to be here. People say they have made friends with the other people living here." A further staff member said, "I just love the people. I am sociable and I love it. It feels like a second home." A staff member said to us that they felt, " "You need to be happy around people so they know they can talk to you and that makes them feel welcome."

Throughout our inspection visit, we observed positive interactions between people and staff. People appeared comfortable with staff, and we saw staff speaking with people with kindness and respect. For example, when people needed reassurance, this was given. Some people had their hair styled by a visiting hairdresser and were complimented by staff in how they looked. One person smiled at staff and said, "It's nice to get a compliment on how I look, my hair feels lovely now."

People told us staff involved them in making day to day decisions about their care. For example, about where they wanted to spend their time and what they wanted to do. Some people gave us examples of decisions they made and one person told us, "Staff get me washed and dressed at 5am. I'm happy to get up early." Another person told us, "I ask the night staff get me up, so I don't have to wait for the day staff and until 9am." Both of these people told us they were happy with the times they were supported to get up and felt if they wanted to change their mind staff would accommodate them.

Some people took part in 'resident meetings' and minutes from these showed they were used as a means of asking people if they were happy with their care and updating people about planned events, such as menu changes and entertainment.

People felt that staff respected their privacy and dignity. Staff gave us examples of what they did to ensure people's privacy was respected, one staff member commented, "We make sure we knock on people's doors." During our inspection visit, we observed that people's privacy and dignity was promoted, for example when staff supported people with personal care tasks.

One staff member said they felt helping people to be independent was also about making sure you offered choice. They commented, "I try to encourage people to do anything they can for themselves. I would say, 'Would you like me to wash your face or would you like to do it yourself?'"
One staff member told us, "We try to encourage people as much as we can. Perhaps someone can shave themselves for example, or wash part of their body but not their back." Another staff member told us they

made sure people had equipment, such as their walking frame, close to them so people could be as independent as possible.

People said their friends and relatives were able to visit them at any time and there were no restrictions. One relative told us, "I think I can visit any time, I've never been told anything different."

Requires Improvement

Is the service responsive?

Our findings

Overall, people felt their needs were responded to and care was personalised to them. People told us they were happy living at the home and gave us some positive feedback about staff. One person said, "The staff are good and I've no complaints about them." Another person said, "I can do a lot for myself, generally the staff are around to help me if needed."

However, a few people told us they had to wait for staff when they needed support. One person told us, "Staff have told me not to use my walker on my own, but I do because I can't always get staff help when I need it." Another person told us, "I need help to get to the toilet, sometimes I have to wait when they (staff) are busy."

Staff were able to give us examples of how they would support people in ways that were sensitive to their needs, which could change from day to day. Talking about one person who could, on occasions, become anxious and want to leave the home, one staff member explained, "[Person's Name] sometimes says they want to leave the home to pick their kids up from school. This happened a few weeks ago. I asked them where they wanted to go, and they told me this. We sat down, chatted about it for a bit, had a cup of tea and after a short while everything was fine."

However, we observed staff were not always consistent in supporting people in a sensitive way. For example, at lunchtime a staff member informed people of the choice of puddings and one person said they would like 'lemon sponge'. We observed the staff member tell this person they could not have the lemon sponge, but could only have 'tapioca or a bowl of custard'. This person repeated they'd like the lemon sponge to the staff member, who rather than discreetly and gently reminding this person of the reasons it was not advisable for them to have the lemon sponge, just repeated what they had already told this person. The staff member later added a further choice of a yogurt, which this person agreed to have. We found this staff member had not effectively responded to this person asking for something that would not be safe for them to eat.

During our inspection visit, we observed most people's needs and requests for support were responded to in a timely way by staff. However, we saw a few examples of when people's needs were not responded to. For example, when we arrived at the home at 9.30am, we saw one person wearing a jumper with spillages making it wet. We observed staff did not offer any tissues to this person or change their clothing. When we left the home at 6pm, this person was still wearing the same soiled jumper. We discussed this with the registered manager and they told us, "This person dribbles a lot and does not have many clothes."

Communal areas of the home were staffed throughout the day and we observed when people called out for staff attention, staff went to them and asked if they could help. However, staff did not always take the initiative to offer support. For example, when one person got up from sitting at the dining table and walked backwards, they were unsteady and had not gained their balance but the staff member watching did not approach to assist them manoeuvre with their walking aid.

People's care needs were assessed and their relatives had been involved in initial assessments to plan care. One relative told us, "We have given some information about my relation's likes and dislikes so staff have information they need." Most people told us they felt involved in day to day decisions about their care, but could not recall being involved in reviews about their care and support. One person told us, "There's a chart on my bedroom wall about my care, but it's so full of inaccuracies, we don't follow it anymore." We saw charts stuck on people's bedroom walls that gave an overview of their care and support needs, one staff member told us, "I think most of them are up to date, but some might need changes." One person we asked could not recall being asked if they wanted personal information displayed on their bedroom wall.

Care plans included a 'This Is Me' section, which gave staff the opportunity to record information on people's likes, dislikes, what was important to them and what made a good and bad day for them. These had been completed, however information was very brief. Whilst the care plan section called 'This is Me' was intended to be brief, we found other sections of people's care plans did not provide staff with further information to enable them to personalise care in a consistent way.

People spoken with could not recall being invited to or taking part in a review of their care and support. However, a few relatives felt they were involved in their family member's care planning and reviews. One relative told us, "I think my family member's needs have changed and I am going to ask for a meeting. I have not been invited to one but feel I can ask for one." Care plans recorded recent reviews and most consisted of a brief sentence that stated 'no change'. We found there was no documented review meeting or discussion involving people and / or their relatives. Staff did record day to day messages and conversations with relatives. For example, one care record showed staff had informed one person's relatives of a hospital appointment and another person's birthday celebrations.

We looked at how people spent their time in the home and saw some people independently pursued interests and hobbies, such as reading, watching TV and chatting to others. People told us they felt there were enough activities offered to meet their needs. During our inspection visit, the activities staff member encouraged people to take part in a bingo session. The activities staff member told us, "We use wooden boards and wooden numbers which makes bingo a more interesting and tactile activity for those who want to participate." One person told us, "I really enjoy the bingo and quizzes." One person used a magnifying glass so they were able to take part in the session.

One person told us, "We've had some good days out arranged for us. I've been to the local garden centre, on a boat trip plus we've had celebration days here and used the garden. I enjoy my television but also the activities offered by staff here." Another person went into the garden and told us, "I like to have some fresh air and can come outside when I want to." A few people were cared for in bed due to their health conditions and the activities staff member told us, "I offer a one to one session with people in their bedrooms once a week."

Overall, people and their relatives told us they had no current complaints about their care they or their family member received. One relative said, "We've raised a couple of issues in the past about missing items, but the manager has always responded and items have been found." One staff member told us if a person raised a complaint or concern with them, they would, "Chat with the person to see what it was about. I would also record it and report it to the manager." The registered manager showed us details of two complaints received this year and we saw actions had been taken to resolve these. Two concerns recently made by people were currently being investigated.

We found the registered manager, who is also the provider of the service, had not implemented an independent process where people and their relatives could go if they were not satisfied with the outcome

of a complaint investigated by the registered manager.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in October 2015, we identified improvement was needed to the governance of the home. The quality assurance audits were not always effective and had not identified issues we had found. For example, a medicines improvement plan, agreed with the local authority, had not been implemented effectively, and medicine audits had not identified issues we found such as people's medicine dosages were not always clear or recorded by staff. People's personal information was not stored securely at the home. At this inspection, we looked to see if improvement had been made and found storage arrangements for people's personal information had improved. However, medicine audits had failed to identify issues we identified on this inspection visit which meant improvements the registered manager informed us had been made had not been effectively implemented.

Systems were in place to audit the quality of services. The registered manager told us, "We have just completed our initial analysis from feedback surveys sent to people in August 2016, and I have an action plan to implement and some points to discuss with staff." The response rate to the feedback was only 28% and the registered manager had recorded that this low response could be taken to imply 'everyone is fairly happy. 'Consideration had not been given to offering people alternative and accessible formats that some people may find easier to use than the written questionnaire to increase the participation of those giving feedback. Overall, most comments were positive and reflected that people were happy living at the home and felt well cared for. However, we also saw a few negative comments had also been made, for example, one comment described a staff member as 'bossy, rude and spiteful.' The registered manager informed us that in light of the feedback being anonymous they did not know who this related to, so planned to address this by letter to all night staff reminding them to have a kind and caring approach. We found the action plan did not identify how checks would be made to determine whether improvement had been made, to ensure people felt they were always supported by caring staff. The registered manager informed us they had planned a 'resident meeting' for the following month to discuss the survey feedback.

Accidents and incidents were recorded and analysis took place so that actions were taken to reduce the risk of reoccurrence. However, we found the registered manager's actions were not always implemented by staff and spot checks on staff had not identified this. For example, ensuring staff gave people their call bells so they could gain staff attention when needed.

We looked at how the registered manager ensured the safe management of medicines and the system of checks and audits so that improvement and learning could take place when needed. We saw a staff member had recorded three separate incidents, over the past few months, of spillages of medicines. We discussed these spillages with the registered manager and they told us there was no formal reporting system in place for medicine errors and incidents, but the staff member had verbally reported the spillages to them. They told us no investigation had taken place for these medicines that staff had informed us were handled as controlled drugs in the home. This meant that opportunities were missed by the registered manager to improve staff practices and the safe handling of medicines in the home.

We identified that the registered manager had not ensured an effective system was in place for care staff to

record when they applied prescribed creams to people and this meant there were no records of topical items being applied as directed by people's GP.

The registered manager informed us that they, or a team leader, completed weekly medicine checks and a monthly medicine audit. We found these checks had not identified issues that we found. For example, these weekly checks had not identified medicines that we found had been placed in the 'returns box' by staff when the medicine had still been required by a person living at the home. Checks and audits had not always identified recording errors such as staff signature gaps on people's medicine administration records (MAR) or failing to record medicine details in the controlled drugs book. We found medicine discrepancies had not been identified by checks, for example, the amounts of some people's medicines was not always accurate. One person had 29 tablets in stock when their MAR showed that they should only have had 26 left. This meant that three tablets had been signed for as given by staff but were still in the packaging.

The registered manager told us that they undertook checks on staff skills and training records showed us staff had completed care skills training. However, we found sufficient oversight of the effectiveness of staff training was not undertaken by the registered manager. For example, medication competency assessments of staff were not effective and had failed to identify where improvement was needed.

We asked to look at infection control audits and were told these formed part of the daily health and safety checks. However, these checks had not been effective in identifying risks of cross infection that we identified. For example, we found new incontinence pads were stored in open packs next to toilets; on the floor in ensuites and on the toilet cisterns which presented a risk of cross infection. We saw unused flannels placed on toilet cisterns and bed rail bumper covers stored on the floor in ensuites next to a toilet. We discussed risks of cross infection with the registered manager and they told us, "We do have some limited storage issues. We have not had any outbreaks of diarrhoea and vomiting here."

Care plan audits were not always effective and had not identified where action was needed. For example, one person's care record information sheet stated they had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) but there was no DNACPR form in their care record. We saw other people had DNACPRs but audits had not identified the need to review these to ensure the information on them was still accurate. For example, one person's DNACPR has been agreed and dated in 2011 but no review of this had taken place.

Care plan audits had not identified issues we found. For example, one person was described to us by staff as having behaviour that challenged, however we found no details of this in their care record or how staff should support this person. A further example we found was that staff did not always have the information available to them to manage risks to people. Care plan information ensures staff take a consistent approach to meeting people's needs and audits of care records had not identified any need to include further information or review important decisions.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager informed us they split their time between this home and their domiciliary care agency, and said, "I spend at least two and half days a week here, but more often three days, and I can be contacted by phone if staff need me. I have two team leaders who have designated tasks." One team leader informed us they had recently returned to work after planned leave and were in the process of "getting back up to speed with getting to know new people living at the home and any changed needs people had." The other team leader informed us, "I'm more office based and do the records, such as meeting minutes and

food orders. If needed, I can always phone the manager and they will come to the home or give advice over the phone. "

Staff told us they felt supported and that the registered manager was approachable. One staff member said, "If you go to the manager and you are unsure of anything, they are always supportive and they are available to phone if they are not here in the home. We can even phone when they are on holiday. It's never a problem." Staff told us they had one to one supervision meetings with either the manager or team leader and also met regularly as a team. One staff member told us, "We had a team meeting recently but I couldn't attend, so the manager asked me if there was anything I wanted to raise." Meeting minutes were available for staff to refer to if they had not attended.

We were informed, by the registered manager, that two concerns had been brought to their attention by people and they explained their staffing policy and procedures were being followed in dealing with this. We found the registered manager was very open about the allegations of concern made to them, however, we had to remind the registered manager to send us a statutory notification form as required about these issues and to inform the local authority, which they did.

On the day of our inspection visit, we gave feedback to the registered manager. Following this, the registered manager sent us an action plan telling us about 'urgent actions' they were taking to make improvement to the issues we had identified to them. These included an investigation into why medicine was not administered to one person, implementing an incident reporting system for any medicine spillages or discrepancies, so that investigations and learning could take place, and putting a recording system in place for staff to use when applying people's prescribed creams. The registered manager also informed us appropriate storage for open packs of incontinence pads would be used and they would be removed from the current storage arrangements.

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 had not always assessed the risks to the health and safety of service users and had not done all that is reasonably practicable to mitigate any such risks. The provider did not have a proper and safe management of medicines system.

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 Systems and processes to assess, monitor and improve the quality and safety of the services provided were not always effective. Systems and processes to assess, monitor and mitigate the risks to the health, safety and welfare of service users were not always effective.

The enforcement action we took:

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