Care Quality Commission

Abbeyfield Society (The)

Wilford House

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 8 February 2018 and was unannounced. Wilford House is divided into three separate floors and provides support and care for up to 30 older people. At the time of this inspection 23 older people lived at the home, some of whom were living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This was the first time Wilford House had been inspected under its current registration. The home had previously been registered under a different provider. This was therefore the first time the service had been rated Requires Improvement.

There was an experienced registered manager in post on the first day of our inspection visit. Following our inspection visit the provider notified us that the registered manager was on leave from the home for an unspecified period. An interim manager had been appointed to manage the home in their absence.

A requirement of the service's registration is that they have a registered manager. 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.

The provider was not consistently identifying and managing risks to people at Wilford House. Environmental risks were not always managed to ensure people were protected against harm. In addition, the provider was not managing the risks of infection to people at the home. Medicines were not always managed safely.

People's rights to have their personal details held securely and confidentially was not being respected. People were not always offered opportunities to participate in leisure and recreational activities of their choice, or to meet their social needs.

The provider did not always follow the principles of the Mental Capacity Act 2005 by ensuring that people consented to their care, or were supported by authorised representatives to make decisions.

Care records and documentation required improvement to ensure there were full, up to date records of the care people needed and the care they received.

The provider did not have effective systems in place to assess, monitor and improve the quality of care people received at the home.

Staffing levels were sufficient to provide safe care and support to people. Recruitment procedures ensured people of good character were employed at the home.

People were supported to access a range of health care services. When people became unwell staff responded and sought the appropriate support.

The provider reported and investigated accidents, incidents and safeguarding issues when these arose.

People's nutritional needs were met and they were supported to eat and drink sufficiently to maintain their health.

People said staff were kind and respectful toward them. People's feedback on the service was sought by the provider. People told us they felt they could raise concerns or complaints if they needed to.

We found there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

We found the environment at Wilford House required improvement to ensure people were always cared for in a safe place, free from hazards. The provider was not always identifying and managing individual and environmental risks to people at Wilford House. Medicines management required improvement to ensure people always received their medicine when they should, by trained staff. People felt safe living at Wilford House and staff had been recruited safely. The provider reported and investigated accidents, incidents and safeguarding issues when these arose. There were enough staff employed at the home to provide safe care for people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff completed an induction and training so they had the skills they needed to effectively meet people's needs, however, the provider did not keep an up to date record of staff training to monitor when refresher training was due. Where people could not make decisions for themselves, important decisions were not always documented to show they were made in their 'best interests' in consultation with health professionals and people who were important to them. The design of the premises did not always support people to move around safely and confidently. People received food and drink that met their preferences and health needs. People were supported to see healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider did not ensure records were kept securely and confidentially. Staff knew people well and respected people's privacy and dignity. Staff treated people with care and kindness. People were able to have friends and relatives visit them when they wished.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to take part in social activities in accordance with their interests and hobbies. People's care records required review to ensure they were up to date and met their current needs. People did not always have end of life care planning in place, to involve people in decisions that took into account their wishes and preferences. People were able to raise complaints and provide feedback about the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager was on leave from the home when we completed our inspection process; however, the provider had appointed an interim management team during their absence. Quality assurance procedures required improvement to ensure checks identified where improvements were needed.

Care Quality Commission

Wilford House

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 8 February 2018 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service.

Before our inspection visit, we looked at and reviewed the Provider's Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR did not always reflect the service provided.

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

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with five people who lived at Wilford House and two relatives of people who lived at the home. We gathered feedback from staff including the registered manager, a senior manager, the chef, a team leader and two members of care staff.

We looked at a range of records about people's care including four care files. We also looked at other records relating to people's care such as four medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of checks the registered manager and the provider made to assure themselves people received a quality service. We also looked at recruitment and supervision procedures for members of staff to check that safe recruitment procedures were in operation, and staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

The provider was not always identifying and managing environmental risks to people at Wilford House. For example, at our inspection visit we found some windows on the first floor of the home did not have window restrictors fitted. This posed a risk to people if they were tempted to open the window fully and attempt to leave the building, as these windows led onto a flat roof. Some people at the home were living with dementia, confusion and short term memory loss. We were aware that two people were subject to restrictions on their care, which meant they were unable to leave the home without supervision. We brought these risks to the attention of the senior manager at Wilford House. Following our visit they confirmed to us that a contractor had fitted window restrictors in February 2018.

We saw on the top floor of the home there was a series of attic rooms which were being used for storage. This area at the home was accessible to people, staff and visitors. We found the area was not locked, and some items in the area posed a potential risk to people. For example, a maintenance cupboard was left unlocked which contained work tools and sharp objects. We brought these risks to the attention of the senior manager. They later confirmed to us that a contractor was brought in to fit locks to the area in late February 2018.

We also found people were not protected against the risk of scalding; we identified one radiator in a communal area of the home that was not covered with a radiator cover. Radiator covers are commonly used in care homes to protect people from burns. We also found very hot water pipes around the home were unprotected, especially on landings and stairways. We brought these risks to the attention of the senior manager at Wilford House. They later confirmed to us that a contractor was brought in to review uncovered pipes, and pipes around the home were boxed in late February 2018.

There were a number of carpets around the home that were damaged, for example, one carpet leading into the downstairs corridor from a bathroom was torn. In one person's room we saw their carpet was torn and posed a trip hazard to them. Most of the carpets in the corridors around the home required replacement as they were threadbare. Some people at the home used mobility aids such as walking frames, which may become stuck on the carpet causing people to fall.

We brought these risks to the attention of the senior manager at Wilford House. They later confirmed to us that a contractor was brought in to renew flooring in some areas of the home. Following our inspection visit the provider also confirmed that replacement flooring in the dining room, first floor bathroom, several residents' rooms and the ground floor corridor had already been ordered and booked for installation when we inspected the service.

In addition, following our inspection the provider instigated a health and safety check, to be completed every three months by the management team to check environmental risks around the home. We were told that there was a current vacancy for a maintenance worker.

People told us Wilford House was homely. All the people we spoke with told us their bedrooms were as

clean as they would expect their homes to be. Comments included; "Yes, it's as clean as I'd like it to be", "Everywhere is spotlessly clean" and, "The dining room has fresh serviettes and the tablecloths changed regularly."
However, we were concerned that some areas of the home could be cleaner. This would help staff prevent the spread of infection. For example, we observed the tops of some radiators were very dirty, some carpets were dirty and some high areas such as ceilings and light fittings were visibly dirty.

In addition we saw that toilets did not always have hand basins, which prevented people from washing their hands immediately after using the toilet. People needed to go into their own room, or a bathroom with a basin, to maintain their cleanliness and prevent the spread of infection through cross contamination.

We brought this to the attention of the senior manager during our inspection visit. Following our visit the senior manager told us they planned to undertake a full infection control audit by the end of March 2018. This was to include a review of hand washing facilities and cleaning schedules.

Individual risks to people's health and wellbeing had not always been identified, and risk management plans were not always in place to instruct staff on how they should mitigate the risks to people at the home. For example, we saw one person who displayed behaviours that could be challenging to them and others particularly when they became anxious. In addition, when the person became anxious or excited they shouted loudly, especially during a specific game they liked to play. There was no information in the care records to inform staff how to reduce their anxiety or excitement levels to reduce the shouting, which could disturb other people at the home. There was no information for staff on how they should approach the person, to reduce their anxiety if they became aggressive with staff or other people at the home.

Staff who administered tablet and liquid medicines received specialised training in how to administer medicines safely; they completed training before they were able to administer medicines and had regular checks to ensure they remained competent to do so. People told us they received their medicine when they needed it.

However, care staff who applied creams to people's skin did not have the same level of training to administer medicines, and were expected to administer topical medicines to people's skin whilst supporting people with their personal care. Care staff undertaking this task did not complete medicine administration records (MAR) to show this had been done; records were being completed by other medicines trained staff. This meant we could not be sure staff who completed records knew if people received their medicine.

We found medicines were stored securely either in the medicines room, medicines trolley, or when in people's bedrooms. Most medicines were monitored to ensure they were stored at the correct temperatures, so they remained effective. Only creams kept in people's rooms were not monitored to ensure they remained within the correct temperature range to ensure their effectiveness.

Some people at the home were able to administer some of their own medicines, which were kept in their bedroom. This promoted people's independence and choice. However, we found the provider did not have risk assessments and risk management plans in place, to assess whether this posed a risk to the person or other people at the home, and how these arrangements could be managed to reduce the risks.

Some people required medicines to be administered on an "as required" basis. There were no protocols (plans) for the administration of these medicines to make sure safe dosages were not exceeded and people received their medicine consistently. These protocols would support staff to make consistent decisions about when people needed their medicine, for example, if they were in pain.

We found some medicines needed to be taken at a certain time, or with a certain gap between each dose of the medicine. These were not recorded when they were given to people. For example, some pain relief medicines require a gap of four to six hours between doses to ensure people are not given too much medicine. Although there was a place to record the time these medicines were given, on the back of the MAR, this was not being recorded by staff.

Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed. MARs contained a photograph of the person so that staff could ensure the right person received their medicines. However, three of the MARs we checked showed gaps in the administration of some medicines, so we were unable to confirm people had received their medicines as prescribed.

We were told by senior staff there were daily checking procedures in place to identify if there were any recording gaps in the administration of medicines. However, we found no explanation had been recorded for the gaps we identified during our inspection visit. We also found auditing procedures were not in place to regularly check medicine administration, or count the amount of stock that was in storage at the home. This meant we could not be sure that medicines were always being accounted for, or being given. The provider had failed to identify the issues we identified during our inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

All the people we spoke with told us they felt safe at the home. One person said, "I feel safe here and well looked after." We saw people did not hesitate to ask staff for their assistance, which showed they felt comfortable around staff members.

We had received concerns before our inspection visit from an anonymous source, that staffing levels at the home were not sufficient to support people safely at night. We therefore reviewed the staffing levels at the home during the day, evening, and night time.

We found there were sufficient staff on duty at the home to provide safe care to people. The provider had reviewed the number of staff on duty just before our inspection visit. This was because of concerns that were raised by staff at the home. The provider had changed shift patterns to increase staffing numbers at busy times of the day, so that from 6.30am each day there were at least three staff available to support people to get up, and from 3.00pm to 10.00pm each evening there were at least three staff available to support people to go to bed. During the day there was a minimum of three care staff on duty, plus a team leader and a manager. Between 10pm and 6.30am there were two staff on duty to support people during the night, if they required assistance.

Some people told us staffing levels needed to be increased at night. However, we were unsure whether these comments related to a time before the shift patterns were changed at the home. Comments from people included; "There aren't enough staff at night especially if there is an emergency.", "I sometimes go to the toilet on my own but I prefer some support." The same person went on to say, "I feel they could do with more staff at night." We asked people whether their safety was affected. People did not describe to us an impact on the quality of care they received, with one person saying, "If I buzz them they come quite quickly."

Staff told us they felt there should be more staff on at night, as before the current provider took over the running of the home there had been three staff on night duty. We asked staff what the impact had been, with one less member of staff working at night. Comments from staff included; "Everything is rushed.", "Sometimes people wait for the toilet." However, staff said they still had time to make hourly checks on

everyone during the night.

The senior manager explained that they were currently recruiting more care staff to cover holiday and sickness periods. They were also recruiting a new maintenance worker to assist with environmental maintenance.

Staff told us and the PIR confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of staff. All prospective staff members had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

Accidents and incidents were recorded to show when and where accidents happened in the home, and whether risks could be mitigated to reduce the number in the future. The provider had taken measures to minimise the impact of unexpected events happening at the home. This was to ensure people were kept safe and received continuity of care. For example, emergencies such as fire and flood were planned for, so any disruption to people's care and support was reduced.

People were protected against the risk of abuse. Care staff told us they completed regular training in safeguarding people. Staff were knowledgeable about the procedures for identifying and reporting any abuse, or potential abuse. Staff told us they were comfortable with raising any concerns they had with the management team, and were confident any concerns would be investigated and responded to. The provider had procedures in place to report safeguarding concerns to local authorities for investigation, and to CQC.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. 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 (DoLS).

The registered manager had reviewed two people's care needs to assess whether they were being deprived of their liberty, or their care involved any restrictions. No mental capacity assessment was in place to establish the support these people required, however, applications for a DoLS authorisation had been made.

Where people lacked the capacity to make all of their own decisions, mental capacity assessments had not been undertaken to establish what support was needed for the person to be involved in making specific decisions. Mental capacity assessments should be time and decision specific, according to each decision made. Where decisions were made on behalf of the person there were not always documents in place to explain how decisions had been reached, and who had been involved in the decision making process when they were in the person's 'best interests'. The provider had not obtained evidence that people's relatives were legally authorised to make decisions about their finances or their care and welfare, when they had made such decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Consent.

The senior manager told us, following our inspection visit, that paperwork to record mental capacity assessments and best interest decisions was being put into place during a care record review, being undertaken at the home before the end of March 2018.

However, staff understood that they should ask people to consent to their care every day, and explain to people what they were doing to support them. We saw staff asked people for their permission when offering them support.

We found that people had an initial assessment of their health and care needs when they came to the home. However, these initial assessments had not been regularly updated to ensure people's current needs were being met. For example, we saw one person was asked to consent to their own care and treatment when they came to the home in 2013. However, they now had a diagnosis of dementia, and we could not see how this diagnosis had changed aspects of their care and support plans.

All staff received an induction when they started work at the home which included working alongside experienced members of staff. The induction covered a number of courses the provider considered

mandatory such as manual handling training, and safeguarding people from abuse. Following the induction programme and a probationary period, staff told us their training was then kept up to date, and their skills were refreshed so they continued to be competent in their role.

However, the provider was unable to demonstrate when staff had received refresher training to keep their skills up to date, because there was not an up to date centralised list of training. We also found a gap in the training of staff. For example, all staff were not trained in administering medicine to people when they were required to do so.

We saw staff used their manual handling skills effectively when assisting people to move around the home safely. We saw people being assisted to move from chair to chair carefully, safely and respecting the person's dignity.

Staff told us they received regular support and advice from their line manager, which enabled them to do their work. Senior care staff worked alongside care staff, so knew people and the tasks staff needed to perform well. They were therefore able to provide advice, but also to observe the practice of staff at the home. There was an 'on call' telephone number they could call outside office hours to speak with a manager. Regular team meetings and individual meetings between staff and their managers were held. These gave staff an opportunity to discuss their performance and any training requirements. The provider told us they had recently introduced a new schedule to hold regular one to one meetings with staff and their line manager.

Most people at Wilford House were able to find their way around the home without assistance. However, to provide people with guidance if they needed it, the provider had not placed any picture signs to indicate where the lounge, dining room, and toilets were located. People did not have a sign on their bedroom door with their name, or pictures to help them locate their room easily. We brought this to the attention of the senior manager during our inspection visit, as people at the home were living with dementia and short term memory loss, which could cause them some confusion. They told us they would review the use of such signs at the home before the end of March 2018.

In the lounge area there was information on display to assist people in recognising the day of the week, and the time of year.

All the people we spoke with commented that the food was very good at Wilford House, saying there was always a choice of meal. One person said "I have a funny diet but there is always something catered for me." Another person said "I don't have a special diet, but food is quite pleasant." During the breakfast and lunchtime meal service we saw people enjoyed their meals

The dining room was calm and there was a relaxed atmosphere. Tables were set with tablecloths, mats, cutlery, flowers and condiments to make the mealtime experience a sociable and enjoyable event. Some people drank wine with their meal, other people chose water or fruit juice.

People made choices each day about what they wanted to eat from freshly prepared food. A daily menu was displayed in the dining area, and people were asked for their choice of meal before it was prepared. The chef told us, "However, if people want something different, this is no problem."

Most people were able to eat without any assistance from staff. Where people needed support to eat, we observed staff provided this support appropriately and sensitively. Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. People also had drinks

available in their room and they were always placed within their reach. People commented that there are always drinks available. A trolley came around with hot drinks regularly at set times each day, and there was a choice of three cold drinks available in each lounge area throughout the day. One person said, "Some people get drinks in the night too."

Staff supported people to choose what snacks they wanted to eat and when. Snacks were available throughout the home, which included sweet treats and fruit.

Kitchen staff knew people's dietary needs and ensured they were provided with meals which met those. For example, some people were on a soft food diet or were diabetic. Information on people's dietary needs was kept up to date and included people's likes and dislikes.

People were supported to maintain their healthcare needs and had access to healthcare services. People told us when they needed a doctor one visited the home to see them. One person was attended to by the district nursing team to treat their skin. We also found that a weekly visit from a nurse to assess people's health needs had been put in place. We saw several instances where advice was provided by visiting health professionals which was transferred to care records.

Requires Improvement

Is the service caring?

Our findings

We found the provider did not always protect people's right to privacy. On the top floor of the home we found a number of storage boxes which contained people's care records, health records and medicine records which could be accessed by people, visitors and staff as the room was not locked. This did not respect people's right to have their personal details protected under the Data Protection Act 1998.

We brought this to the attention of the registered manager and senior manager at Wilford House. They later confirmed to us that a contractor would fit a lock to the room before end February 2018. They also intended to arrange training for staff on Data Protection.

People said staff were kind and caring. One person told us staff were helpful. Another person said, "On the whole they support me to have a good quality of life."

People were asked whether they had any specific cultural or religious needs during their initial care planning, and people were also assessed to see how best staff could communicate with them. Some people had sensory impairments such as some sight loss. The registered manager told us that information using alternative formats, such as audio, was available for people who needed this. Other people had been offered hand held computer devices to assist them with their communication, but these were not currently being used as people did not wish to. One lounge had a hearing loop near the television to help people hear more clearly.

We observed how staff promoted people's independence during our visit. Staff encouraged people to move around independently, with staff at hand to help should it be required.

We saw staff knocked on people's bedroom doors and waited to be invited in. We saw staff were caring and responsive when a person's situation may have caused them embarrassment. They supported the person in a quiet and discreet way.

There were a number of communal areas where people could meet with friends and relatives in private if they wished. This included lounges, conservatory areas and dining areas. People made choices about who visited them at the home, and were supported to maintain links with friends and family. Family members said they could visit at any time they like.

Each person had their own room and were able to decorate or furnish their rooms how they wished. We saw rooms were personalised, people had pictures of family and friends around them.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always up to date which did not provide staff with all the information they needed to support people in a person centred way, taking into account their health and personal preferences. Up to date care plans were important as the home could employ temporary staff who would not know people well. Relatives told us they were concerned about their relation because they felt care staff did not know the person's needs, which could impact on their care if the care records were not kept up to date.

Whilst people or their relatives had been involved in planning their care when they came to the home, care records lacked information on how relatives and people were involved in reviews of their care, when things changed.

In addition, we found people had not always been consulted about their wishes and preferences for their care needs at the end of their life. They had not been given the opportunity to discuss what type of medical or health interventions they wished for, if they became ill.

We brought this to the attention of the registered manager and senior manager during our inspection visit. The provider later told us they planned to review all care plans and people's wishes by the end of March 2018.

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

Staff told us they were able to respond to how people were feeling, and to their changing health or care needs because they were kept updated about people's daily support needs at a handover meeting at the start of each shift. The handover meeting provided staff with information about any changes in people's needs since they were last on shift.

People were not always supported to pursue interests and hobbies which met their individual needs and wishes at the home. People told us they felt there should be more to do at the home. Comments from people included; "We don't have many activities here. That's the worst thing about it." and, "We don't do activities regularly or any exercises." One person said, "They sometimes have a man who comes in and sings, and sometimes we play throwing a ball into a basket."

There was no designated member of staff to engage people in hobbies and activities each day, or to organise trips out and about in the local community. There was no daily activity schedule on display at the home, to involve people in planned activities.

People did not have individual activity plans in place, to record what things they enjoyed doing, or to utilise their knowledge and experience to pursue hobbies they might enjoy. We saw one person who was living with dementia, who spent all of their time during our inspection visit watching the television in their room.

Activities people were engaged in included occasional visits to the home from an entertainer, and people from local religious groups offering people spiritual guidance and communion.

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home. People told us they knew how to raise concerns with staff or the registered manager if they needed to. A typical response from people we spoke with was that they had never needed to make a complaint. We saw people regularly approached staff and the registered manager and with everyday queries throughout our inspection visit.

Only one person we spoke with had felt the need to make a complaint and had done so by talking to the registered manager of the home. The person felt their complaint had been handled appropriately as it was followed up and acted upon. Previous complaints had been investigated and responded to by the registered manager or provider.

Requires Improvement

Is the service well-led?

Our findings

Following our inspection visit the provider notified us that the registered manager was on leave from the service. However, the provider had arranged an interim manager and senior manager to support staff at the home until the registered manager returned.

The provider had failed to ensure systems and processes were in place, to ensure the home was managed safely and consistently, and that people received safe care.

There were several safety concerns at the home, including environmental issues and the lack of effective risk management which we identified during our inspection process. The provider had failed to identify these areas required improvement using their own monitoring systems.

Care records required review to ensure they were up to date and met the current needs of people at the home Medicines records were not always up to date and consistently completed to evidence when people received their medicines.

There was a lack of management information to ensure the home was well led. For example, there was no up to date record to show when staff had received training and when it was due to be updated.

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

Following some of the concerns we raised at our inspection visit, the provider had instigated a health and safety check, to be completed every three months by the interim manager to check environmental risks around the home. We were told that there was a current vacancy for a maintenance worker which was now being recruited for.

People at Wilford House said that they would recommend it to their family and friends. They said that the atmosphere in the home 'feels homely and caring.'

People and relatives told us they knew who the registered manager was, during our inspection visit. They stated they were happy to provide feedback to the registered manager or staff at any time. The relatives we spoke with said they had a good relationship with the management team, who updated them about their relative's health and progress when they visited the home.

We viewed some improvements plans which were already in place regarding updating of the environment, the review of care records, and actions already taken to improve medicines management and nutrition. This demonstrated that the provider had already undertaken some work at the home to make required improvements.

The provider and registered manager listened to the feedback people gave them through regular

satisfaction surveys. However, we found people did not have an opportunity to discuss the running of the home at regular meetings organised by the provider.

The provider understood their responsibilities to report issues and concerns to CQC.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care of service users did not always meet their needs and reflect their preferences, because the provider did not carry out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured care was being provided with the consent of the relevant person. The provider did not always act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users. The provider had not assessed the risks to the health and safety of service users, and done all that was practicable to mitigate any such risks. The provider had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Systems and processes were not established and operated effectively to ensure the provider was meeting the Health and Social Care Act 2008. The provider did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider did not maintain securely and accurate, complete and contemporaneous record in respect of each service user.