The Trustees of the Earley Charity

The Liberty of Earley 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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 and 9 January 2017. The first day of the inspection was unannounced. The service was last inspected in July 2015. At that inspection we found the service required improvement in the areas of 'Safe' and 'Effective', although no specific breaches of legislation were found. As the result it was rated 'Requires Improvement' overall.

This was a comprehensive inspection to follow up all of the previous areas of concern and review the overall compliance of the service. We found the service had made improvements in some areas but identified three breaches of the regulations which are detailed below.

The Liberty of Earley House is a care home without nursing that provides care for up to 35 people with needs relating to old age. Twenty four hour support is provided by a team of staff. At the time of this inspection, 22 people were receiving support. The service is operated by The Trustees of The Earley Charity.

A registered manager was in place as required in the service. 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.

We found that despite the range of steps taken by management, the previously identified issue of significant medicines errors had re-emerged, which placed people at potential risk of harm. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2014.

The trustees (the registered provider), carried out monthly monitoring visits to the service. However, these had not always identified key issues requiring action in a timely way. Health and safety issues had not always been effectively managed proactively to ensure action was taken promptly to address concerns. This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2014.

Further improvement was necessary in some aspects of management overview and proactive action, by both the registered manager and the trustees. We recommend that the registered manager and provider seek recognised guidance regarding their responsibilities for health and safety matters.

Staff had not received a consistent level of support through supervision and performance appraisal in accordance with the provider's own expectations or the requirements of legislation. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2014.

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

Feedback from people and relatives about the care and support provided by staff was positive although some people recognised staff were under a lot of pressure to meet people's needs due to recent staff shortfalls. People felt safe and well cared for and said they were treated with dignity and their privacy was respected by staff.

People had been involved in reviews of their care and felt they had a say in the support they received. They felt the service responded to their changing care and health needs. They knew how to make a complaint if necessary and felt involved and consulted through the residents meetings. Although people's views were sought through survey forms as part of trustee visits it was not clear how this information was collated and used to develop the service.

People's rights and freedom were protected by staff who sought their consent before providing support or accessing their flats. People were provided with a varied menu with daily options and the range of activities and entertainment was being developed in response to people's requests.

The service had a robust staff recruitment system to help ensure staff were suitable to work with vulnerable people. New staff received a thorough induction to the service and premises. However, progress on the national 'Care Certificate' induction training process (or equivalent), had been slow. The service had yet to establish a comprehensive system of competency assessment to ensure all staff had up to date knowledge of their role and responsibilities. Good progress had been made with staff training and courses had been booked to address remaining shortfalls, although a need for additional training in some areas was identified.

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 had been put at risk of potential harm due to significant numbers of medicines errors. Other aspects of medicines management, such as storage, were satisfactory.

Health and safety issues were not always managed to ensure required servicing and remedial works were carried out in a timely way.

People felt safe and well cared for. Staff had been trained and understood how to keep people safe.

The service had a robust recruitment system in place to try to ensure prospective staff were suitable.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received supervision support or development appraisals to ensure they were knowledgeable enough to meet people's needs appropriately.

Progress on introducing a robust induction process had been slow and comprehensive competency monitoring was not yet in place.

People felt the service met their needs effectively.

Improvements had been made to training provision and courses were booked to address remaining shortfalls.

People's rights and freedom were safeguarded by the service.

People were provided with a varied menu and had daily choices of meals.

Is the service caring?

Good

The service was caring.

People felt staff were caring and kind.

People were treated with dignity and their privacy was respected although formal staff training in this area had not been provided.

Staff supported people to make day to day decisions and choices about their care.

Is the service responsive?

Good

The service was responsive.

People felt the service was responsive to their needs.

People's care plans had been revised with them and were detailed and person-centred.

Adaptations had been made to the building in response to people's changing needs.

The range of activities, entertainment and outings was being improved in response to feedback from people.

People had opportunities to raise any concerns they might have through a variety of forums.

Is the service well-led?

Requires Improvement

The service was not always well led. Further improvement was necessary in some aspects of management overview and proactive action, by both the registered manager and the registered provider, (the trustees).

The trustees carried out monthly monitoring visits to the service. However, these had not always identified key issues requiring action in a timely way.

People and staff's views about the service were sought on a sampling basis. It was unclear how their feedback was used to support future development of the service.

The Liberty of Earley 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.

We last inspected the service on 7 and 8 July 2015. At that inspection we found the service was compliant with the essential standards we inspected. However further improvements were required in some areas and it was therefore rated as 'Requires improvement'.

This inspection took place on 6 and 9 January 2017 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with five people, about their experience of the service.

We observed the interactions between people and staff and saw how staff provided people's support. We had lunch with people on the first day of the inspection.

We spoke with five of the care staff and two administrative staff. The registered manager was off sick at the time of this inspection. Prior to the inspection we contacted placing local authorities to seek their views. They raised no concerns about the service. We also spoke with visiting healthcare professionals about the service and no concerns were raised.

We reviewed the care plans and associated records for three people, including their risk assessments and reviews, and related this to the care we observed. We examined a sample of other records to do with the home's operation including staff recruitment, supervision and support records, surveys and various monitoring and audit tools. Copies of some additional records were requested and provided by the service

following the inspection.

Requires Improvement

Is the service safe?

Our findings

At our inspection in July 2014 the provider was not meeting the requirements of the then Regulation 13, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds with Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015.

At the following inspection in July 2015 we found the registered manager had introduced a range of monitoring and recording improvements to address the previous medicines errors. The new systems included a 'Do not disturb' tabard for the medicines administering person, better recording and checking for errors and omissions as part of handover between staff shifts. Medicines storage had also been relocated to dedicated medicines cupboards away from other distractions. These changes had reduced the level of medicines errors at the time of the previous inspection. The registered manager reported a further reduction of medicines errors on completion of the 'Pre-inspection Information return' in July 2016.

However, when we examined the current medicines administration records sheets we identified 12 gaps in administration records. This meant that, potentially, people had not been administered their medication. The registered manager's analysis of these instances showed all but two had been recording omissions where the person had received the medicine due. Two administration omissions had occurred, which were investigated and addressed through refresher training. Further follow up of these and the recording errors was to take place in the seniors meeting following the inspection. The handover checks of medicines records had not been recorded by the seniors on numerous occasions. This meant the cause of a potential error might not always have been identified in a timely way so it would not have been possible to address any omissions promptly, putting people at risk.

Senior staff members pointed out that with current vacancies there had not always been the usual two seniors on duty, which was felt to have contributed to the failures to check records. In addition, the forms to record handover checks of medicines were kept in the office, rather than with the medicines trolleys, which was said to make the process more lengthy. Medicines competency checks had not yet been completed, although senior staff had received medicines training and did observe the process carried out by an experience colleague several times before administering medicines themselves. Although no harm had resulted, the recording and administration errors placed people at potential risk of harm, either from medicines omissions or dosages not being provided as prescribed.

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

Medicines were administered by senior carers supported either by the duty senior or a carer, where two seniors were not available. The service used a recognised system where most medicines were placed in labelled blister-packs by the pharmacy. Administration was recorded on standard medicines administration record (MAR) sheets. Four people were able to manage their medicines for themselves. The others required various degrees of support with this. Where a person was self-medicating, this was noted on the MAR sheet.

The service had obtained pharmacy-filled dosette boxes for one week's medicines at a time for two people, to reduce possible confusion, while still enabling self-administration. The MAR sheets were kept with the medicines trolley on each floor to make the recording process as efficient as possible.

MAR sheets included a record of medicines received and a separate log of returns was kept, enabling monitoring to take place. Where people were on PRN (as required) medicines, each person had a protocol identifying when the medicine should be given and how the need for it was to be established. This helped to ensure people received these medicines appropriately. However, it was not clear whether staff should be recording when they offered PRN medicines, because this was not done consistently. Records sometimes noted when they had been taken, and at other times, also noted when they had been offered and declined. Records of medicine room and fridge temperatures were kept to ensure appropriate storage.

The majority of health and safety checks and periodic servicing had taken place as required and the relevant certification was available. The fire risk assessment and health and safety policy had both recently been reviewed. A safety improvement plan had been compiled and was being worked through to maintain health and safety related issues. It had been revised in December 2016. The record of testing of the electrical circuitry in March 2016 had identified a number of issues which needed to be addressed but this was not included in the safety improvement plan. At the time of this inspection, the remedial work had still to be carried out, which potentially put people at risk. An approved contractor had recently been identified by the trustees but no date had been agreed for the completion of work. Following the inspection, arrangements were made for the completion of these remedial works with appropriate planning to keep people safe whilst they were carried out. No recent gas safety certificate could be found. The service made contact with a relevant contractor immediately following the inspection and a gas safety inspection was carried out with satisfactory results.

Staff were unclear whether thermostatic safety valves were fitted to all hot water outlets to safeguard people from the risk of scalding. The service took immediate steps to have the hot water system inspected to ensure that any such shortfalls were addressed. Once all outlets were protected in this way the service planned to establish a cycle of regular temperature checks and periodic servicing to ensure protection was maintained.

We recommend the registered manager and provider seek recognised guidance regarding their responsibilities for health and safety matters to ensure they meet the requirements.

People and relatives felt people were safe and well cared for in the service. One person told us, "I am happy, I feel safe," although they preferred to be supported by staff who were known to them rather than from an agency. Another person said, "I feel safe here and well looked after."

No safeguarding issues had arisen since the last inspection. Staff had attended safeguarding training in May and June 2016 and understood their role in keeping people safe. Senior staff had identified risks to one service user, relating to their own chosen behaviours. The service had taken steps to minimise the risk but the person had been reluctant to take appropriate advice.

Appropriate steps had been taken in response to specific identified hazards. For example it had been identified that some falls had arisen due to people having difficulty managing the door to their flat when using frames. In response, appropriate holdbacks had been installed on these doors to enable people to remain as independently mobile as possible. People were asked to wear pendant alarm activators in addition to having alarm cords located in key places within their flats. This helped ensure they would be able to summon assistance wherever they were in the building. A night time fire drill had been held to ensure night staff knew how to respond to emergencies.

Since the previous inspection risk assessments had been revised and improved and were subject to regular monthly review. Appropriate risk assessments were completed for falls, nutrition and hydration, moving and handling and skin integrity for each person as part of measuring their overall needs and dependency. Where risks were identified we saw steps had been taken to reduce these. For example, in the case of potential trip hazards in one flat, staff had worked with the person to agree appropriate changes in layout. Where people wished to continue using equipment which could present a risk to them, such as a kettle, they signed a disclaimer confirming they took responsibility for this. Where bedrails were used to prevent falls from bed, this was with the individual's consent and at their request.

The recruitment records for the most recent staff member demonstrated that the system was robust. All the required evidence was available, including the outcome of the criminal records check, copies of references and of documents confirming identity. A full employment history was provided and a completed copy of the in-house induction was on file.

Staff felt the service had suffered due to some understaffing recently after the departure of the previous deputy manager and some other staff. Morning staffing on the first day of inspection was three care staff, (one being an internal relief staff), one senior carer and a relief duty senior, plus administrative and ancillary staff. This was being achieved with some reliance on internal relief staff at the time of inspection. The afternoon/evening staffing was two care staff and a senior while occupancy was reduced. If the service was at full occupancy the staff compliment was increased by one care staff on each shift. The registered manager preferred not to use external agency staff to maximise the continuity and consistency of care. Instead the service had a number of relief staff available to provide cover when requested.

Requires Improvement

Is the service effective?

Our findings

At the time of the previous inspection in July 2015 some shortfalls in training were identified. Senior staff said there had been a lot of training provided more recently. The training information was collated for the whole team and showed significant progress on training. Where training remained overdue, for health and safety, fire safety and a medicines update, courses were already booked in February and March to address this. According to the records provided most staff had yet to complete training on dignity, privacy and person-centred care. The registered manager told us this will be addressed once staff completed the relevant Care Certificate workbooks.

Ongoing training was being planned with external trainers as part of a learning and development programme for the service. Courses were being planned for infection control and other core areas but there was a need for training on dementia, given that more people were starting to experience living with dementia.

One senior care staff had attended training to enable them to provide moving and handling training to care staff, which meant this could be provided more flexibly than when relying on external courses. Staff had received updated moving and handling training in May 2016 following some concerns identified about staff practice. The training had included some observation of moving and handling practice although comprehensive competency assessments, which would be best practice, had not yet been completed. One of the administrative staff had attended training to enable them to provide health and safety training to staff. Following some previous concerns about the level of staff knowledge regarding strokes, additional training had been provided to staff on recognising and responding them to help ensure prompt recognition and action.

At the previous inspection in July 2015, we found staff had been provided with irregular support through supervision meetings and had not attended performance appraisals. To some extent this had been made worse by the absence of a deputy manager during the period. The registered manager set up a new system to help ensure staff received regular supervision to ensure they were supported to enable them to give people good care. This included sharing supervision responsibilities between the senior staff. Senior staff responsible for staff supervision had been provided with supervision training in 2016 to support them in this role. The providers target was for staff to receive supervision at least every six-weeks to provide opportunities to reflect on their work and discuss training or other needs. In addition, staff should have attended an annual performance appraisal with the manager. No overview of supervision and appraisal dates was available. The registered manager acknowledged they had fallen behind with supervisions and appraisals.The lack of competency checks also meant the registered manager had no way of assessing the competency of her staff.

The information provided following this inspection showed there were still significant gaps in people's supervision. Some staff had attended between one and five supervisions in the last 12 months. However, twenty four staff had no recorded supervisions in the previous 12 months. No staff annual performance appraisals had taken place. This meant many staff had not had regular opportunities to discuss and reflect

on their practice and any training or development needs. The registered manager said senior staff shortfalls had continued to impact on their performance in this area and undertook to prioritise this in future.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2014.

Nevertheless, people and relatives felt the service met people's needs effectively. One person told us, "I'm looked after well, very impressed with the care I get." Another told us, "I'm glad I found it [the service]." One person had been impressed with the care previously provided to their husband within the service. People and relatives gave some mixed feedback about the staff. One said staff were, "All very nice" and another said, "They use their initiative." Another person told us most of the staff were OK but two could be rather abrupt at times. Feedback from external healthcare professionals was positive with regard to the care provided by staff. One health professional said, "The staff were very friendly and helpful, listened when I gave advice about particular residents and acted on it."

New staff were provided with a detailed induction to the service and premises, including health and safety and fire safety. New staff were then asked to complete the national Care Certificate induction process. The registered manager also asked existing staff who did not have a recognised qualification in care, to complete the care certificate assessments to ensure all staff had the necessary up to date knowledge and skills. However, progress on the Care Certificate had been slow to date and competency testing needed to be undertaken as a priority, to ensure staff put their training into practice when supporting people. The registered manager had attended training in 'Assessing Vocational Achievement' to enable her to enable her to support staff through their 'Care Certificate'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Most people had capacity for day to day decision making and were free to come and go within and outside the service. Their care plans placed no restrictions on their movement.

One person's needs had increased and review discussions were being held with family with regard to whether their needs could still be met within the service now they no longer had capacity. A capacity assessment had been completed by the local authority and a referral made for Deprivation of Liberty Safeguards (DoLS) authorisation to enable staff to ensure they were kept safe pending decisions about their future placement. They had been referred to the GP for additional support around dementia. The DoLS authorisation arrived during the inspection.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberties Safeguards (DoLS).

People's rights and freedom were safeguarded by the service. Staff sought consent from people before providing personal care support. Specific consent was sought for additional aspects of care such as staff access to people's flats and the use of bed rails at night. Records of consent were present on people's files. Where the person was happy to involve their family, they too were involved in decisions about care. Two people had appointed others to have power of attorney for decision making once they were unable to do so themselves. Three people had recorded advance decisions regarding their wishes at end of life and a further three had completed advance care plans regarding their wishes. Where people had forms on file regarding

non-resuscitation, these had been discussed with them or their representatives, by the GP completing the form.

People were mostly happy with the meals provided. One person told us, "I like the food here." Another said, "The meals are good and very varied." One person said that although there was a choice it was difficult to change your mind once you had chosen your meal in advance. They felt the meat could be tough at times and the vegetables sometimes overcooked. Another told us, "The breakfast club is popular."

Most people ate lunch and teatime meals in the dining rooms and had breakfast in their flats from food of their choice, provided to them. People could choose to have all meals in their flat. On Fridays the service held a popular 'breakfast club', where people could attend the ground floor dinging room for a cooked breakfast of their choice. The menu for the following week was provided to people so they could select their meals from the choices offered.

Two people previously on food and fluids monitoring no longer required this due to improvement in their intake. They were now monitored via monthly weighing and had been signed off by the dietitian. One person's food intake was carefully recorded and monitored daily due to their fluctuating food intake. Another had their intake monitored only during periods of low intake. People were weighed monthly as part of monitoring wellbeing. The service had sought the advice of the Speech and Language therapy team in the past where people had swallowing difficulties. However, no one required this support at the time of this inspection. The dietitian service had also been consulted for advice. One person had supplements provided but had declined them.

People praised the healthcare provided by the service and said the doctor was called in when necessary and staff responded promptly if you were unwell. Historically the service supported people with minimal care needs who were largely independent. More recently the level of people's needs had increased and more of them required support with aspects of personal care. For example, only four people now managed their own medicines. One person was unwell and being cared for in bed. Support and advice had been sought from external healthcare specialists as appropriate, including the 'pain clinic' and the 'Parkinson's clinic'. One external healthcare professional had raised some concern about staff knowledge of mental health issues. Additional training was subsequently provided to staff around the Mental Capacity Act 2005.

The premises were divided into self-contained flats or bedsits over two floors, with an additional adapted bathroom on each floor. Communal dining rooms were provided on each floor and a communal lounge on the ground floor. Corridors were wide and provided with small seating areas. The communal areas were bright and reasonably spacious. Each flat had a kitchenette and wet-room shower/toilet. Each flat had its own front door to which people had their own keys. The grounds were attractive and well maintained and provided with a patio, level paths and seating. A central kitchen prepared main meals which were delivered to the dining rooms via heated trolley.

A range of adaptations had been provided to address people's increasing frailty and support mobility. These included various hoists, toilet and other handrails, toilet seat risers, shower seats and adapted baths. An evacuation chair was provided for the stairs in the event of emergency. Adapted crockery and cutlery was available if required and individual preferences were respected.

Good

Is the service caring?

Our findings

People and relatives were happy that staff were caring. One person said, "The staff are kind here" and another told us staff were, "Very good and kind" and "Very encouraging." People described how they decided about aspects of their daily lives such as the time they got up, whether to join in activities and what meals they ate.

Feedback from external health professionals was positive with respect to the caring approach of staff. One told us, "Interaction with residents was always appropriate and very good from what I had seen."

People's spiritual needs were provided for by visiting clergy if they were unable to attend outside services. At the time of inspection, representatives of two denominations visited the service and one person regularly attended an external place of worship. People were asked about their individual wishes regarding care towards the end of life to help ensure staff were aware of their preferences and could put them into place when the time came.

People were encouraged to make day to day decisions and choices for themselves and to live as independently as they were able within their own flats. Staff treated people's flat doors as the front door to their accommodation. Staff only accessed the flats with people's explicit consent and people's individual wishes around this were recorded.

The service was good at personalising people's experience around medicines. For example, one person preferred to take their medicines at a set time, which was provided for, and another was enabled to take a specific medicine after breakfast according to their wishes. Four people managed their own medicines following completion of a risk assessment.

Since the previous inspection the number of people requiring minimal or no personal care support had reduced significantly. Staff keyworkers spoke to each person on a regular basis to check that the care and support provided still met their needs. Where issues arose negotiations had taken place with individuals to try and resolve them. For example, where conflicts had arisen between people's chosen lifestyle and the need to keep them safe, discussions to identify and minimise risk had taken place with them.

Staff worked in ways that respected people's dignity and privacy although formal training in these areas had not been provided. Not all staff appeared totally comfortable with providing the increased levels of support now required by some people within the service. On occasions the responses of particular staff showed a lack of understanding of people's needs, for example in responding in a negative or defensive way to criticisms made. This was also reflected in some of the feedback received from two people.

One person had been unsettled by a male agency staff they did not know, responding to their bell to provide personal care support. When the agency worker reported this back to the senior a female staff member was provided appropriately and provided the support. Following discussion during the inspection it was agreed people would specifically be asked about any gender issues regarding personal care support, and any issues

recorded, to avoid a recurrence of this.

Where people were able and had capacity, they had keys to their front door and the service and could come and go as they pleased, just having to let staff know when they were going out for fire safety purposes. People who required no personal care support were able to go about their lives as they wished but staff checked in with them daily to ensure all was well. Where people required some prompting around their personal care or medicines needs this was done in such a way as to maximise their dignity.

Good

Is the service responsive?

Our findings

People and relatives felt the service was responsive to their needs. One person described the care provided to them as, "Proactive" and added that staff responded promptly to the call bell. This view was not shared by another person, who felt staff didn't always respond promptly when called. Another person said they were, "Well looked after by staff." They also explained how staff had helped them up, using a hoist, when they had fallen. Feedback about such things as the frequency and diversity of activities was mixed. Some people felt these needed to be improved. One person said, "I like the food but there are not that many activities. I join in what I want, I like the quiz." Another person said they enjoyed the keep fit and some of the outings. Overall people enjoyed what was provided but would appreciate either more variety of activities or some of them being provided more frequently.

An external healthcare professional praised the service for having sought regular support from the audiology service, who had been asked to run a regular drop-in clinic at the service. This enabled people to get prompt help with hearing aids and other issues.

It was noted that one senior staff had been responsible for re-writing most of the care plans in a more detailed format in consultation with people, to make them more person centred. It was planned to involve people's keyworkers more in the process in future, once staff were used to the new format. Some family members had been consulted, where people were happy for them to be involved.

Adaptations had been made to the environment in response to people's increasing needs. For example the handrails had been coloured to enable them to stand out for people with visual impairment. Some doors had been re-hung to open the other way to make it easier for people to negotiate the doorway. For the future there were plans to possibly develop a sensory garden area.

Care plans and associated records were detailed and contained the information necessary to enable staff to provide individualised care. People's plans identified the level of care support needed in various aspects of their lives and noted where encouragement or prompting was necessary. Care plans were supported by individual risk assessments and information was used to monitor people's overall dependency to identify changing needs. One person had a temporary care plan in place to reflect recent changes in their needs.

People had regular opportunities to raise any concerns within the monthly resident's meetings. The meetings were minuted and the people attending were asked to agree the previous minutes. We observed the meeting which took place during the inspection. People were asked their opinions about various aspects of their care as well as being provided with information about staffing and other matters. They were told about upcoming activities and events and asked for new ideas for these. Several people commented that the lounge felt cold during cold weather and some said their flats could be a bit cold in the evenings. It was suggested the handyman would look at adjusting the heaters during the current cold weather.

Suggestions were made by several people. Not all of the attending staff responded as openly to the suggestions made, as others. Some slightly dismissive comments were made, which might have

discouraged the person from making further suggestions, particularly around meals. However, some creative suggestions were offered around food, including a Chinese New Year meal and a Burn's night supper. People were invited to suggest other ideas for themed meals. The chef explained the plan for a monthly restaurant style lunchtime meal where people would choose from the menu provided on the tables. It was agreed to make the available teatime options clearer in bold type on future menus as not everyone was fully aware of the range of options.

A programme of planned activities, entertainment and events was posted each month on the notice board for those wishing to take part. While this included various options, there remained room for further development, particularly where hairdressing was the only listed 'activity' on some occasions. People's level of engagement with activities varied. Some chose to have little involvement, while others opted for a busier lifestyle. However, with the increasing levels of dependency people's take up of scheduled activities had increased.

The service complaints procedure was displayed on the lounge notice board and had been provided to people as part of their information pack on admission. It included the contact details for the Local Government Ombudsman and the Care Quality Commission, to whom people could also refer their concerns. People were aware of how to complain although most of those spoken with had not had cause to do so. One person told us they had raised an issue previously and it had been addressed by the registered manager.

The recorded complaints had been addressed and lessons learned. For example in the case of a complaint regarding the service's overriding duty of care whether or not a person has the capacity to make decisions about their own needs. Additional training and guidance had been provided to staff on recognising and responding to strokes, and other recommendations made to the service had been acted upon. The pre-admission assessment process had also been made more thorough to ensure the service had all the information needed to enable an informed decision to be made regarding suitability, and legal status before admitting a new person. Some improvements had also been made to meal choices, activities and resident's meetings as a result of people's feedback.

Requires Improvement

Is the service well-led?

Our findings

People had a different opportunities to raise their ideas and concerns.

A survey of the views of people and relatives had taken place in June 2016. This was not presented at the time of inspection but was provided following the inspection. The results were positive with just a few issues raised which the registered manager had responded to, some of which were also reported to us during the inspection. People's care files contained copies of completed feedback forms regarding their experience of the care provided. Some had been completed monthly or every two months. The feedback recorded was positive. Trustees also spoke with a sample of people within the service during their monthly visits and asked them to complete a survey about their experience. However, it was not clear whether or how these were collated to identify themes or issues requiring action.

Cards were available in the entrance hall for people to provide feedback on the service via the 'CareHome.co.uk' website. Two relatives had provided very positive feedback via this website. One said, "There is a lovely happy atmosphere in the home and the staff are always on hand to help," and "The care and attention they have given [name] has been second to none and he is content and happy." Another relative described staff as, "thoroughly obliging, very conscientious, endlessly kind-hearted, warmly friendly to us, and hugely supportive." Feedback about the approach of staff was positive.

No recent comprehensive staff survey had been carried out to obtain their views about the service and the changes made. However, trustees spoke with a sample of staff as part of their monthly visits and recorded their views. The feedback seen confirmed the inconsistency around staff supervision and appraisal. Staff also fed back their concerns about current staffing and occupancy levels as well as workload. It was not clear what, if anything, the trustees proposed to do to address the identified and reported issues.

Staff meetings were intended to be held monthly, alternately for senior staff and the whole team and discussions were minuted. Although this frequency wasn't reflected in the minutes available, they demonstrated discussion of appropriate areas including care practice, training, medicines, admissions and the impact of staffing levels.

It was not clear how effectively the providers communicated their vision and values to staff within the service. The registered manager had clear expectations with regards to how people were treated and respecting their rights, freedom and privacy. However, the lack of regular supervision, appraisal, monitoring and competency assessment by the management team had contributed to some practice issues re-emerging, such as an increased number of medicines recording errors and some issues of approach in the case of individuals. From comments made during the inspection it appeared some staff were rather demoralised and demotivated.

Daily handovers took place between staff at shift changeovers to help ensure the continuity of care and that key information about changes in wellbeing were passed on. This was done during the handover we observed. Information was passed on regarding medicine changes, action arising from GP and district nurse

visits and individual requests which people had made of staff. The service provided an up to date statement of purpose, which had been reviewed in August 2016. This required amending to reflect changes of senior staff.

The registered manager understood her duties and responsibilities under 'Duty of Candour' (Regulation 20) and had demonstrated this in response to recent issues which had arisen. The duty of candour requires services to be open about events, when something goes wrong and to apologise for errors where these took place. The registered manager had notified the Commission of notifiable events which had arisen. Notifications are reports of events that the provider is required by law to inform us about.

The registered manager did not complete any kind of written monthly audit tool regarding the operation of the service but monitored this informally. She had an action plan which included target dates for addressing issues she had identified. The plan included care and procedural developments such as changes to risk assessment and improving stroke awareness. It also referred to learning areas such as clarifying the balance between 'duty of care' and people's rights, following a previous incident. The issues had been or were in the process of being addressed.

A member of the trustees carried out monthly visits to the service and completed a written report. This referred to various issues, including maintenance, activities, records sampling and summarised feedback obtained from people and staff. However, the overview of the subject areas checked throughout 2016 suggested some key areas were never, or only occasionally addressed. For example, health and safety, training and care plans had only specifically been addressed at one visit, according to the record. The provision of supervision had not been monitored at all. Aspects of medicines recording had been monitored regularly, although not in December when the number of recording errors had reportedly increased again.

Despite the completion of these visits it was not clear that trustees had made themselves sufficiently aware of some issues which had arisen in the service. As a result, trustees had not always acted in a timely or proactive way to address safety concerns. For example the remedial electrical safety works described earlier. Action was taken following this inspection and work was commenced to address these issues later in January 2017. The failure to identify and proactively address overdue health and safety related work demonstrated ineffective governance on the part of the service's trustees whose monitoring systems should have identified and addressed these issues in a more timely way. Trustees had also been made aware of the lack of regular supervision and appraisal through staff feedback during their visits but it did not appear this had led to specific monitoring to establish the extent of this or the discussion of possible solutions with the registered manager.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2014.

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 Care and treatment was not provided in a safe way for service users with regard to 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 Effective systems were not in place to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity had not received appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.