Westlands Retirement Home Ltd

Westlands Retirement Home

Inspection report

17-19 Reed Vale
Teignmouth
Devon
TQ14 9EH

Tel: 01626773007

Date of inspection visit:
14 June 2018
15 June 2018

Date of publication:
30 August 2018

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

Summary of findings

Overall summary

This unannounced inspection took place on 14 & 15 June 2018. Westlands Retirement Home is a 'care home.' 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.

Westlands Retirement Home is registered to provide personal care and support for up to 20 older people some of whom may be living with dementia or physical frailty. The home does not provide nursing care; people living there would receive nursing care through the local community health teams.

On the afternoon of 14 June 2018, the provider informed us they had admitted another person for planned respite care. The person was admitted to a vacant room, which had previously been registered. We explained to the provider that they were in breach of a condition of their registration and asked them to send the required notification, which they did. This meant there were 21 people living at the home and the provider was in breach of a condition of their registration. The home is now registered to provide accommodation and support for up to 21 people.

The home did not have a registered manager at the time of the inspection as the registered manager had recently retired. A new manager had been appointed; they had applied to become registered with the Care Quality Commission and were available throughout this inspection. They are referred to as the manager throughout this report. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

We looked at the home's quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality and safety of the services provided. Although some systems were working, others had not been effective, as they had not identified the concerns we found during this inspection.

People were not always protected from the risk of avoidable harm. We found risks such as those associated with people's complex care needs, medicines, recruitment and the environment had not always been assessed or managed safely. Where risks had been identified, guidance had not been provided to staff to mitigate these risks. Although systems were in place to identify and record accidents incidents, there was no consistent system in place for analysing and identifying patterns to prevent a reoccurrence.

Whilst some premises checks had been completed we noted others had not, we found a number of bedroom windows were not risk assessed so the provider could not judge if they were properly restricted, and safe. There was no evidence the provider had carried out any form of risk assessment in relation to needs of people currently living at the home and the risks posed by having unrestricted windows that were

accessible.

People were not always supported by staff that had the necessary skills and knowledge to meet their needs. Records showed that staff inductions, supervisions, and annual appraisals were poorly documented. There was not an effective system in place to ensure staff were provided with the necessary training and support to meet the needs of the people they supported.

People's needs were assessed prior to coming to live at the home. This formed the basis of a care plan, which was further developed after the person moved in and staff had gotten to know the person better. We found people were at risk of receiving care that did not meet their needs as some people's care plans contained outdated or misleading information. None of the care records we saw were being regularly reviewed or updated in line with homes expectations.

People received their prescribed medicines on time and in a safe way. However, we found medicines were not always stored safely, as the home did not have a robust system to ensure that people or unauthorised staff could not access medicines.

People told us there were enough staff to meet their needs. One person said, "They [staff] are here when I need them." However, staff told us there were not always enough staff to meet people's needs especially during the evening and at night. We discussed staffing levels with the provider and manager who told us there were enough staff on duty to meet people's needs but they did not have a system for deciding how many staff were needed in relation to the number of people who lived in the home and their level of dependency.
We have recommended that the provider uses a suitable tool to ensure staffing levels are sufficient to meet people's assessed needs.

We checked whether the home was working within the principles of The Mental Capacity Act 2005 (MCA). We saw staff obtaining people's consent. However, where a person's capacity to make complex choices or decisions was in doubt records did not show staff had assessed the person's capacity. Where decisions had been made in a person's best interests, these were not being recorded properly and it was not clear these were the least restrictive.

Westlands Retirement Home is set over four floors, which meant in many ways it was not an ideal environment for the needs of the older people living there, although there was a lift to the upper and ground floors. The environment was not adapted to meet the needs of people who may be living with dementia or a sensory impairment. There was very little signage throughout the home and bedroom and bathroom doors were hard to distinguish.

We have made a recommendation in relation to the suitability of the environment.

People told us they were happy living at the home and liked the staff that supported them. Relatives told us they did not have any concerns about people's safety. People were protected from the risk of abuse. People were encouraged to share their views and could speak to the provider and manager whenever they needed to. People were aware of how to make a complaint and felt able to raise concerns.

We have made a recommendation in relation to the management of complaints.

People were encouraged and supported to engage with a range of healthcare services and staff supported people to attend appointments. A visiting healthcare professional told us they did not have any concerns

about the care and support people received, staff made referrals quickly when people's needs changed and followed professional advice.

Most people told us they enjoyed the food provided by the home. Comments included, "The food is very good," "It's very nice I can't complain," and "There is always at least two choices each day." We spoke with the chef who had a good understanding of people's likes and dislikes. Details of people's food allergies or special dietary requirements were available in the kitchen and regularly reviewed

We received mixed views about the level of activities the home provided. Some people told us there was plenty to do and they enjoyed spending time with each other, taking part in quizzes, playing board games or going on trips to places of local interest. One person said, "There is always something going on." While other people told us, they were board and felt the level of activities provided by the home were limited. The home produced a monthly activities programme and we saw people had different opportunities to socialise and take part in activities if they wished to do so.

The registered provider had not always notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities.

We found 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

Some aspects of the home were not always safe.

Risks to people's health, safety and well-being were not always being effectively assessed, managed or mitigated.

People were not protected from receiving care from staff who may not be suitable to work in the care profession. Safe recruitment practices were not always followed before staff started work.

There were enough staff on duty to meet people's needs. However, the provider did not have a systematic approach to assessing staffing levels to ensure they could meet the needs of people living at the home.

Staff were aware of how to identify and respond to allegations and signs of abuse and how to raise any concerns.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The home was not always effective.

The principles of the Mental Capacity Act 2005 had not been followed in relation to obtaining consent and best interests decisions.

Some improvements were needed to ensure staff had the necessary skills and knowledge to meet people's assessed needs in safe way.

The provider did not have a system in place for ensuring staff received supervision, support, or professional development.

People's health care needs were monitored and referrals made when necessary.

People were supported to maintain a balanced diet.

Is the service caring?

Good

The home was caring.

People were positive about the care and support they received and felt staff were kind, caring and treated them with respect.

Staff displayed caring attitudes towards people and spoke about people with affection and respect.

People's privacy and dignity were respected and their independence was promoted.

People were involved in the planning of their care and were offered choices in how they wished their needs to be met.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Requires Improvement

Some aspects of the home were not always responsive.

People were at risk of not having their care needs met in a consistent way that respected their wishes and preferences.

Care plans did not provide easily accessible information for staff about people's care needs and how people wished to be supported.

People enjoyed a variety of social activities.

People had information to enable them to raise any complaints or concerns they had about the home. People felt these would be dealt with in a timely way.

Is the service well-led?

Requires Improvement

The home was not always well led.

The provider had not complied with the conditions of their registration.

The provider had not notified the CQC of incidents at the home as required by law.

Although quality assurance systems were in place, they were not being used effectively or undertaken robustly enough to identify the issues seen during the inspection.

The home valued and responded to people's feedback and the provider and manager were well regarded by people, relatives and staff.

Westlands Retirement 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 was 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 home under the Care Act 2014.

This comprehensive inspection took place on 14 and 15 June 2018. The first day was unannounced; this meant the provider did not know we were coming. The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home. The expert-by-experience for this inspection had experience in the care and support of older people living with dementia and complex needs. They spent time with people, relatives, and staff to gain their views of the home.

Prior to the inspection, we reviewed the information we held about the home. This included statutory notifications we had received. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the home, what the home does well and improvements they plan to make.

During the inspection, we met with most of the people living at the home and spoke with 12 people individually, as well as two relatives, four members of staff, the chef, manager, and the nominated individual. A nominated individual is responsible for supervising the management of the regulated activity provided.

We asked the local authority who commissions the home for their views on the care and support provided at Westlands Retirement Home. Following the inspection, we received feedback from one healthcare professional and four relatives.

To help us assess and understand how people's care needs were being met, we reviewed six people's care records. We looked at the medication administration records and systems for administering people's medicines. We also looked at records relating to the management of the home: these included five staff recruitment files, training records, and systems for monitoring the quality of the services provided.

We used elements of the short observational framework for inspection (SOFI) tool to help us make judgements about people's experiences and how well they were being supported. SOFI is a specific way of observing care to help us understand the experiences people had of the care at the home.

Requires Improvement

Is the service safe?

Our findings

The home was not always safe. We found concerns in relation to the understanding and management of risk, people's medicines, recruitment, and the environment.

The systems in place to help reduce and minimise risks to people's health and safety were not always effective. Further improvements were needed to help ensure staff understood people's needs, and to ensure the right action was taken to reduce the risk of harm. For instance, we reviewed the care records for six people who had been identified as being at 'very high risk' of developing pressure ulcers. Records showed staff completed risk assessments and recorded that all six people had been provided with specialist pressure relieving airflow mattresses. We found four of the six mattresses had not been set correctly for the person weight. For example, one person's mattress was set for a person of 180kgs; records showed the person using the mattress had weighed 65.6kgs in June 2018. Another person's mattress had been set for a person of 90kgs; records showed the person using this mattress had weighed 60.4kgs in June 2018. This meant that people had been placed at avoidable risk of developing pressure ulcers.

We brought this to the attention of the manager who was unable to tell us how this had happened. They arranged for the settings of all pressure relieving equipment in use within the home to be checked. There was no evidence people had been adversely affected or had developed pressure ulcers due to the incorrect setting.

Where risks had been identified by staff, action had not always been taken to minimise the risks of reoccurrence or protect people from harm. Records showed accidents and incidents were recorded, but it was unclear how this information was being reviewed or what action the provider had taken to reduce the risk of reoccurrence. For example, in April 2018 incident records showed staff had contacted the police for assistance as one person had left the home unattended via an unlocked patio door and side gate. There were no records to show that following this incident the person's care plan or risk assessment had been updated or that staff had been provided with any additional guidance in relation to the security of the building. We checked the patio door with the manager and found it unlocked and the provider had not taken any action to secure the external gate. This meant people were being placed at risk as they were still able to leave the property without staff knowledge. We brought this to the attention of the provider and manager who told us they would take action to secure the external gate and assured us they were getting advice in relation to the current security arrangements as they had identified that the current system need upgrading.

People received their prescribed medicines on time and in a safe way. However, we found medicines were not always stored safely, as the home did not have a robust system to ensure that people or unauthorised staff could not access medicines. Each person had their own individual medicines cabinet in their room. Keys were kept in a key safe in the downstairs office. We found the office door was not always locked when left unattended and the key to the key safe had been left in the lock. Medicines which required additional storage, excess stock and medicines which needed to be returned were kept in the medicines cupboard. On the first day of the inspection we found the medicines cupboard door had been left open and unattended

with the key in the lock. We found the spare key to this cupboard was hanging on a hook in the food preparation area, which was accessible to people, staff and visitors. This meant the home did not have a robust system in place to ensure people or unauthorised staff could not access medicines. We brought this to the attention of the manager who took immediate action.

People were not always protected from the risk of harm as they were living in an environment that may not be safe. A number of bedroom windows were not properly restricted. There was no evidence the provider had carried out any form of risk assessment in relation to needs of people living at the home and the risks posed by having unrestricted windows that were easily accessible. We brought this to the attention of the provider who was unaware of the concerns relating to the environment and assured us they would take action to mitigate this risk.

At the time of the inspection the provider was having work carried out to the front of the home. Where construction works are taking place, the provider must have in place adequate arrangements for protecting people, staff and visitors from construction activities taking place. We found a suitable and sufficient risk assessment had not been carried out in relation to this work. We brought this to the attention of the manager who assured us they would put this in place.

During a tour of the grounds we noted the provider had installed a Seagull deterrent device to one of the ground floor windows. There was no evidence the provider had carried out any form of risk assessment in relation to needs of people living at the home, staff or visitors and the risks posed by having several rigid stainless-steel wires that were approximately 40mm long protruding from a low-level window ledge. We brought this to the attention of the provider and manager who immediately arranged to have them removed.

We reviewed the home's fire safety precautions. Records showed that routine checks on fire and premises safety were not always carried out within the required period, which the home is legally required to complete. For instance, the fire alarm had not been tested since 25 May 2018 and emergency lighting had not been tested between 20 April 2018 and 7 June 2018. We discussed what we found with the provider who told us they were aware that some of the maintenance records were not as up to date as they should be. However, they had recently employed a new maintenance person who would ensure regular fire / maintenance checks were carried out moving forward.

The provider had failed to take sufficient action to ensure care and treatment was provided in a safe way, and that risks arising from people's care and/or the environment were being effectively mitigated or managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, (Safe care and treatment).

Recruitment processes did not always protect people. We looked at the recruitment files for four staff members who were providing care to people and one relief staff member. Whilst some recruitment checks had been carried out promptly, others had not. Three of the files we looked at showed the provider had failed to obtain satisfactory evidence of conduct in previous employment as required under the regulations, before staff stated work. For example, records for one person showed they had started working at the home in March 2017. However, their references had not been obtained until after they started working, in June 2017 and July 2017.

The disclosure and barring service helps employers make safer recruitment decisions and helps to prevent unsuitable people working with people who may be potentially vulnerable. Records for one person who provided cover on a temporary basis showed they had last worked at the home in May 2018. There were no

records to show the home had applied for or obtained a valid DBS certificate prior to this date. The provider had not carried out any additional employment checks and they were working unsupervised. We raised our concerns with the manager and asked them to provide the Commission with evidence the provider was in receipt of a valid DBS certificates or put in place suitable management arrangements until they had been obtained. Following the inspection, the manager confirmed the DBS certificate was now in place.

The failure to complete necessary employment checks before allowing staff to provide care had exposed people to unnecessary risk. This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us there were enough staff to meet their needs. One person said, "They [staff] are here when I need them." Another person said, "I can manage most things on my own, but staff are around if I need them to help." However, staff told us there were not always enough staff to meet people's needs especially during the evening and at night. One staff member said people often have to wait for care. Another said in the evenings "I do feel rushed as I am not able to spend time with people." On the day of the inspection there were four experienced care staff, the manager, and provider, who were supported by a cook, handy person and house keeper. At night people were supported by one waking night staff member and one sleep-in staff member who slept on a sofa in the main lounge and could be woken if needed. We discussed staffing levels with the provider and manager who told us they felt there were enough staff on duty to meet people's needs but following recent staff meeting they had increased the daytime hours and were in the process of looking at staffing levels at night. However, they did not have a system for deciding how many care staff were needed in relation to the number of people who lived in the home and their level of dependency.

We recommend the provider uses a suitable tool to determine people's level of dependency to ensure that staffing levels are sufficient to meet people's assessed needs.

People were protected from the risk of abuse. Staff told us they had attended safeguarding training and what action they would take if they suspected a person was at risk of abuse. Staff demonstrated a good understanding of their role in protecting people from harm they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected.

The home was clean, staff were aware of infection control procedures, and had access to personal protective equipment (PPE) to reduce the risk of cross contamination and the spread of infection. Equipment owned or used by the home, such as specialist chairs, beds, adapted wheelchairs, hoists and stand aids, were suitably maintained. Systems were in place to ensure equipment was regularly serviced and repaired as necessary. Appropriately skilled contractors had completed all necessary safety checks and tests.

Requires Improvement

Is the service effective?

Our findings

Some of the people who lived at Westlands Retirement Home were living with dementia, or had needs relating to their mental health, which potentially affected their ability to make some decisions. We checked whether the home was working within the principles of The Mental Capacity Act 2005 (MCA). We found some people were potentially having their rights unlawfully restricted due to a lack of staff understanding of the Mental Capacity Act 2005 (MCA).

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Whilst we saw staff obtaining people's consent, people's care records did not always show their consent and/or views had been sought in relation to decisions being made on their behalf. This indicated the home was not working in line with the principles of the MCA. For instance, we found people's bedroom doors were alarmed and external doors were locked which prevented some people from accessing the garden. Staff we spoke with did not know if people had consented to these arrangements. Staff told us this allowed them to monitor people's movements to help ensure they were safe and provide assistance especially at night. There were no records to show the rationale for this decision, no mental capacity assessment to show that people did not have capacity to consent to these arrangements or whether this was being carried out in their best interests.

We raised our concerns with the manager who agreed that some people's records did not contain sufficient information to show the home was working within the principals of the MCA and assured us they would address this.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had made an application to the local authority to deprive one person of their liberty in order to keep them safe. We found the person's capacity to consent to these arrangements had not been assessed prior to the application to deprive them of their liberty being made and there was no evidence that a best interests meeting had taken place.

Failure to gain consent from people, or where people were unable to give consent, involve relevant health or social care professionals in best interests decisions is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they had confidence in the staff supporting them. Relatives told us they felt staff were caring and well trained. We looked at the training, induction and supervision records for six staff. Records showed staff inductions, supervisions, and annual appraisals were poorly documented. None of the staff files we looked at contained any form of induction or sufficient evidence to demonstrate their competencies or skills had been assessed during their employment. On the first day of the inspection we spoke with the

chef who was an agency member of staff and had not worked at the home before. This person confirmed they had not been given any form of induction before they started their shift apart from being told what to cook for lunch. We discussed what we found with the head of care and manager who told us they did not have in place a formal induction for agency staff.

Supervisions and appraisals are an opportunity for staff to discuss concerns, work performance and/or training and development needs. Staff told us they felt supported and said the manager was always available should they need to speak with them. None of the records we saw contained sufficient evidence to demonstrate that staff were receiving regular supervision or annual appraisals. We spoke with the manager about this, who explained this had been due to changing roles. However, they had identified this was an area that needed improvement, and told us they were in the process of carrying out supervision with all staff.

The systems in place to ensure that staff had the necessary skills to carry out their duties was not effective, because the record of staff training and training updates was not up to date. Following the first day of inspection, we were provided with a copy of the home's updated training matrix. This showed staff had recently completed training in medication, fire and safe moving and handling and diabetes awareness. The training matrix provided to us identified significant gaps in the training staff had received. For example, staff needed their training to be completed/updated in several key areas which included, MCA and DoLS, first aid, dementia, health and safety and infection control. We discussed what we found with the manager, who told us that staff's training needs were currently being reviewed, a training provider had been identified and some training had recently taken place.

Failure to provide staff with appropriate support, training, and supervision necessary for them to undertake their role is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Westlands Retirement Home is set over four floors, with a lift to the upper and ground floors. The environment was not adapted to meet the needs of people who may be living with dementia or a sensory impairment. There was very little signage throughout the home, bedroom and bathroom doors were hard to distinguish. Some areas of the home were in need of redecoration. We brought this to the attention of the manager and provider who accepted that improvements needed to be made and told of their improvement plans. Where bedrooms had been updated these were clean and fresh looking. However, we noted several bedrooms which had ensuite facilities were not designed in a way that promoted or supported people privacy or dignity as there was limited access and the toilet door opened inwards. This meant people were not able to close the door when sat on the toilet.

We recommend that provider review the accommodation with regard to best practice guidance about creating dementia friendly environments and meeting the needs of with people with a sensory impairment.

People were encouraged and supported to engage with a range of healthcare services and staff supported people to attend appointments. People's support plans included details of their appointments and staff we spoke with knew people well. Staff monitored people's mental and/or physical health and we saw, where concerns had been identified; people were referred to or reviewed by an appropriate healthcare professional. During the inspection, we spoke with a visiting healthcare professional who told us they did not have any concerns about the care and support people received, staff made referrals quickly when people's needs changed and followed any advice they were given.

Most people told us they enjoyed the food provided by the home. Comments included, "The food is very

good," "It's very nice I can't complain," and "There is always at least two choices each day." However, one person said, "We don't have as much choice as I would like but I'm not complaining they (staff) do their best."

We spent time in the dining room observing how people were supported to have their meal. Where people required support to eat they were being assisted at a pace that suited them. However, we noted support was not provided in a prompt way as most people had finished their meals before staff became available. People were able to have their meals in the dining room, the lounge or in their own rooms if they wished. People who did not wish to have the main meal could choose an alternative. People who did not wish to have the main meal could choose an alternative. We spoke with the chef who had a good understanding of people's likes and dislikes. Details of people's food allergies or special dietary requirements were available in the kitchen and regularly reviewed by senior staff to help ensure this information remained up to date. For example, where people required a soft or pureed diet, this was being provided. Food storage areas were clean and there were plentiful supplies of fresh meats, vegetables and fruit, as well as tinned and dried goods.

Good

Is the service caring?

Our findings

People told us they were happy living at Westlands Retirement Home. People's comments included, "The staff are wonderful," "Can't fault it," "I love it, top marks," "I can't fault this place, if they [other people] fault this place they must be really hard to please." One person said, "I choose to live here and I am happy." A relative said, "All the staff are lovely and you can see that people are well looked after."

There was a relaxed and friendly atmosphere within the home. Staff spoke affectionately about people with kindness and compassion. Staff knew how each person liked to be addressed and consistently used people's preferred names when speaking with them. Throughout the inspection, we saw the provider and manager spend time with people and showed a genuine interest in their lives.

People told us they were happy with the care and support they received and said staff were kind to them. One person said, "I cannot praise them enough; they are all lovely and will do anything for you." Relatives spoke highly of the staff and the support they provided. One relative told us their relation was happy, content and well looked after and staff they had met had been kind and thoughtful." Staff told us they enjoyed working at the home and told how they had developed close relationships with the people they cared for.

People felt their views were listened to, and told us staff treated them with dignity and encouraged them to remain as independent as possible. Throughout the inspection, we saw and heard people being supported. Staff spoke with people in a calm and respectful manner, and allowed people the time they needed to carry out tasks at their own pace. People told us they were involved in making everyday decisions about their care and made choices each day about what they wanted to do and how they spent their time. One person said, "Staff always ask how they can help me."

People's preferences were obtained and recorded during their pre-admission assessment. Staff demonstrated they knew the people they supported and were able to tell us about people's preferences. For example, staff told us what people liked to eat, what they liked to do and when they liked to get up and go to bed. We saw staff gently encouraging people to be as independent as possible, were patient and allowed people time to complete care tasks themselves. People told us staff supported them in a kind and considerate manner, which did not make them feel rushed.

People told us staff treated them with respect, maintained their dignity and were mindful of their need for privacy. We saw staff knocked on people's doors and waited for a response before entering. When staff needed to speak with people about sensitive issues this was done in a way that protected their privacy and confidentiality. When staff discussed people's care needs with us, they did so in a respectful and compassionate way.
People's bedrooms were personalised, and furnished with things, which were meaningful to them. For example, family photographs, ornaments and furniture. People were encouraged and supported to keep in contact with their relatives and others who were important to them. Relatives told us they were able to visit at any time and were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving care that did not meet their needs. We found some people's care plans contained outdated or misleading information and none of the care records we saw were being regularly reviewed or updated in line with homes expectations. For example, one person's diet, nutrition & hydration care plan dated April 2017 indicated they did not require a specialised diet. However, at lunchtime we saw this person had been served a puréed meal and staff were thickening their drinks. We discussed what we found with the manager and staff who told us the person had been reviewed by the speech and language therapy team (SALT) as they were having difficulty swallowing. The SALT team had recommended puréed foods and thickened fluids. Records for another person indicated they were at high risk of falls. This person's associated risk assessment dated April 2017 recorded that the person uses a walking frame to move around the home. We found the person was not able to move around the home without support. Staff were assisting this person with the use of a stand-aid and wheelchair.

Some people had been identified as needing specialised support to manage long-term health conditions. We saw staff had been provided with specialist advice and information on how to recognise signs and symptoms that would indicate the person was becoming unwell and what action staff should take if they were concerned. Staff were also provided with specific dietary requirements. However, we found this information had not been used to update the relevant sections of the person care plan. For example, this person's diet, nutrition & hydration care plan stated they could have a normal diet and normal fluids. However, the advice provided to the home stated this person should limit their daily intake of fluids to 1500mls and limit certain food due to their high potassium content. Although we did not find that this person had been placed at increased risk as they were able to manage/ monitor their own food and fluid intake. Staff we spoke with were not all aware of guidance in place.

Failing to provide and make available to staff a clear care plan that meets people's needs and reflects their personal preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person – centred care.

People's needs were assessed prior to coming to live at the home. This formed the basis of a care plan, which was further developed after the person moved in and staff had gotten to know the person better. We looked at the care records for six people with a variety of care needs and found people's care plans contained detailed information about people's health and social care needs. They were written using the person's preferred name and reflected how the individual wished to receive their care. Each section of the care and support plan covered a different area of the person's care needs, for example, personal care, physical health, continence, diet and nutrition, communication and medication. This provided staff with valuable information to enable them to build positive relationships and help them understand what matters to people and how they wish to be supported.

The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment, or sensory loss. All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. CQC have committed to look at the Accessible

Information Standard at inspections of all homes from 1 November 2017. The manager was aware of the Accessible Information Standard and we saw that people's communication needs were recorded as part of the home's assessment and care planning process. This information was then used to develop communication plans and staff we spoke with were aware of people needs as well as any potential barrier that might impact on someone's ability to communicate their needs.

Staff gave us examples of how they had provided support to meet the diverse needs of people living at the home including those related to disability, gender, ethnicity, faith and sexual orientation. For example, the home had arranged for people's spiritual need to be supported by their local church who regularly attended and offered communion. Although there was no one receiving end of life care, the manager and staff told how people were supported at the end of their life to have a comfortable, dignified and pain-free death. We reviewed people's care records relating to their end of life care wishes and preferences. Where people had chosen to have this conversation, their end of life wishes had been recorded.

The home produced a monthly activities programme and we saw people had different opportunities to socialise and take part in activities if they wished to do so. Each person's care plan included a list of their known interests and staff told us how they supported people daily to take part in things they liked to do. People who wished to stay in their rooms were regularly visited by staff to avoid them becoming isolated. We received mixed views about the level of activities the home provided. Some people told us there was plenty to do and they enjoyed spending time with each other, taking part in quizzes, playing board games or going on trips to places of local interest. One person said, "There is always something going on." While other people told us, they were bored and felt the level of activities provided by the home were limited. A relative said, "There is not enough for people to do, but I know they're working on it." We discussed what we had been told with the manager and provider who told us they were aware that the current activities programme was no longer compatible with people needs and showed us their plans to link up with a local activity centre. They planned to facilitate a range of activities for people which included music clubs, exercises, coffee mornings, as well as the opportunity to attend the local memory café.

People were aware of how to make a complaint, and felt able to raise concerns. One person said they would speak to the manager or staff if they were unhappy. The home's complaint procedure provided people with information on how to make a complaint. The policy outlined the timescales within which complaints would be acknowledged, investigated, and responded to. None of the people or staff we spoke with had needed to make a complaint recently but felt confident the manager would take action to address any concerns they might have.

However, we found where people had raised concerns these were not always responded to or resolved in a timely manner. For example, records showed that one person and their family had raised repeated concerns regarding a maintenance issue within their bedroom. Although the home had taken temporary action to prevent a slip, trip or fall, at the time of the inspection the issue remained unresolved and was still of some concern to the person who occupied this room. We discussed what we found with the provider who assured us they would address the person's concerns.

We recommend the provider takes appropriate action to respond to any failures identified by people or their relatives.

Requires Improvement

Is the service well-led?

Our findings

The home was not always well led. At the start of the inspection there were 20 people living at the home. On the afternoon of 14 June 2018, the provider informed us they had admitted another person for planned respite care. The person was admitted to a vacant room, which had previously been registered. We explained to the provider that they were in breach of a condition of their registration and asked them to send the required notification, which they did. This meant there were 21 people living at the home and the provider was in breach of a condition of their registration. The home is now registered to provide accommodation and support for up to 21 people.

The home did not have a registered manager at the time of the inspection as they had recently retired. A new manager had been appointed; they had applied to become registered with the Care Quality Commission and were available throughout this inspection. They are referred to as the manager throughout this report. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

We looked at the home's quality assurance and governance systems to ensure procedures were in place to assess, monitor, and improve the quality and safety of the services provided by the home. The provider used a variety of systems to monitor the quality of the care provided. These included a range of meetings, audits, and spot checks. For instance, checks of the environment, care records, medicines, nutrition, infection control, health & safety, and accident and incidents. However, we found these were not always being carried out on a regular basis.

While some systems were working, others had not been effective as they had not identified the concerns we found during this inspection. For example, the home did not have an effective system in place to assess or monitor staff competence and skills to carry out the role required of them. The lack of supervision and specific training meant the home could not be assured that staff had the necessary skills and knowledge to meet people's assessed needs in safe way.

Although, the provider had a recruitment procedure and policy in place, the quality assurance systems had not identified where checks had not been completed. This meant they did not have a robust system in place to ensure all staff recruited were safe to work with people who were vulnerable due to their circumstances.

Systems in place had not identified that some people's care plans were not being regularly reviewed or updated to reflect their changing needs and in some cases, did not contain sufficient information to demonstrate the home was working within the principles of the MCA. This meant people were at risk of not receiving care in a consistent way which met their wishes. Staff did not always have the information they needed to support people in the way they wanted and the home was not always taking appropriate action to protect people's rights.

People may not be protected from the risk of harm as they were living in an environment that may not be safe. Whilst some premises checks had been completed, risks to people's health and wellbeing had not always been identified, assessed or mitigated.

Although the home was carrying out regular medicines audits these had not identified that people's medicines were not stored safely to ensure that people or unauthorised staff could not access people's medicines.

Failure to ensure systems were effective in assessing, monitoring and improving the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had not notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. This included any incidents, which are reported to or investigated by the police. For example, we found staff had contacted the police for assistance in April 2018 and June 2018. At the time of the inspection the Care Quality Commission had not been notified of these incidents.

Failure to notify CQC of significant events at the home is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

We discussed what we found with the manager, whilst they had not been aware of all the concerns we identified they were aware of the need to improve. Prior to the inspection and in conjunction with the provider they had started to develop a service improvement plan and were in contact with the local authority's quality assurance and improvement team for guidance and support.

People described the new manager as open, honest and approachable. One person said, "I can talk to them [the manager] about anything. A relative said, [provider name] always comes around to say hello and make us feel welcome, [provider's name] works very hard and wants what's best for my mum. Staff were clear about what was expected of them, their roles and responsibilities, were positive about the support they received and told us they felt valued.

There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through handover meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns. Team meetings were held regularly. Staff told us these meeting were useful and the minutes showed staff were actively encouraged to provide feedback and make suggestion that could improve people's experiences of care.

People were encouraged to share their views and could speak to the provider and manager whenever they needed to. The provider told us they encouraged people and their relatives to give feedback about the care and support they received. We reviewed the most recent feedback results and found the responses of the people surveyed were positive.

The manager was aware of their responsibilities under the duty of candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. The manager told us they kept updated about changes in practice via the internet and email correspondence sent out by the local authority and the Care Quality Commission.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not appropriate, did not meet their needs, or reflect their preferences. Regulation 9(1)(a)(b)(c)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were exposed to the risk of harm as care and treatment was not always provided in a safe way.

Risks to people's health and safety had not been identified or mitigated.

Regulation 12(1)(2)(a)(b)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems and processes in place to assess, monitor, and mitigate risks to people. Records were not accurate, up to date, complete, or maintained. Regulation 17 (1)(2)(a)(b)(c)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to operate an effective recruitment procedure exposed people to unnecessary risk. Regulation 19(1)(a)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that person's employed by the service had receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)