Manorville Care Homes Ltd

Manordene

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 October 2018 and was unannounced.

Manordene 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. The service is registered to accommodate up to 22 people. At this inspection, 21 people were living at the service.

There was a registered manager in post who was present during the inspection. 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.

At our last inspection in August 2017, the service was rated requires improvement. Six breaches of the Health and Social Care Act 2008 (Regulated Activities) were identified. We issued requirement notices relating to person centred care, good governance and staffing. We asked the provider to take action and they completed an action plan to show what they would do and by when. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements.

At this inspection, while some improvement had been made, two of the original breaches had not been met and two additional breaches were found. These related to person centred care, good governance, staffing and consent. We have made recommendations about the environment, accessible information and end of life care. You can see the action we have told the provider to take at the back of the full version of the report.

The overall rating for the service remains at requires improvement. This is the second time the service has been rated as requires improvement.

Assessments had been carried out to identify people's health and welfare needs but they had not been continuously reviewed and there was a lack of detailed guidance for staff to mitigate risks. Checks had been completed on the environment and equipment used by staff to keep people safe. People had personal emergency evacuation plans (PEEPS) but these did not contain detailed information about how to support them in an emergency.

The principles of the Mental Capacity Act 2005 were not always followed as Deprivation of Liberty Safeguards (DoLS) applications had not been made for people who required them.

Equipment to reduce the risk of people developing pressure wounds had not been checked to confirm the correct settings for each person.

The building had been adapted to meet people's physical needs and but there was no signage in place appropriate to help people living with dementia to understand. For example where their room was or where the toilets were.

People could not access the garden without staff as this was not safe. All doors to the outside space were locked. Action was being taken by the provider to make the outside space safe for people to access.

The activities co-ordinator worked four days a week for five hours each day which resulted in limited time for people to be supported to follow their interests and take part in social activities of their choice. We observed that in the afternoon there were not always enough staff on duty to support people's needs. Some people told us there were not always enough staff on duty

People were safeguarded from the risk of abuse because staff had received training and knew how to recognise and report abuse. Staff told us that they were confident that any concerns they raised would be taken seriously by the registered manager.

People living in the service were not always supported in a manner that upheld their dignity. During our inspection we observed people without covers on in their bedrooms with the doors open.

Staff were receiving training, supervision and appraisals. However, the registered manager had not received formal supervision from the provider, or an appraisal to identify their training and development needs to enable them to continuously develop their skills and competencies.

People were offered a choice of meals and snacks, however, there was no picture menus for people who needed them. When people needed a special diet and assistance to eat their meals this was provided.

Peoples end of life wishes were not always recorded to ensure that their expressed needs were met during this time. Staff had received training to support people at the end of their life and keep them comfortable. Nurses in the service had received training around end of life medicines and competencies had been checked.

At the previous inspection medicines had not always been managed safely. At this inspection we found that medicines were now managed safely and there had been no errors in administration. People received their medicines when they needed them and their medicines were stored and administered safely. Staff and nurse competency had been checked.

People told us they knew how to complain. All complaints had been investigated in line with the providers policy and resolved.

There was an open and transparent culture within the service. The provider held resident and staff meetings, however, these were not always well attended.

The registered manager and provider wanted the service to be homely and for people to feel that it was their home from home. Staff shared this vision and felt it was important that people should be surrounded by things that made them feel at home. We saw peoples' bedrooms had been personalised.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC checks that appropriate action had been taken. The registered provider had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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.

There were not always enough staff available to provide the care people needed.

Potential risks to people's health and welfare had not been consistently assessed and there was not always detailed guidance for staff to mitigate risks.

People were at risk of pressure wounds as systems were not in place to ensure staff were correctly using equipment.

Staff knew how to keep people safe from abuse and were confident that the manager would act on any concerns they had.

People received their medicines safely and when they needed them.

Accidents and incidents were analysed and action taken to reduce the risk of them happening again.

Is the service effective?

Requires Improvement

The service was not always effective.

The building had been adapted to meet people's needs, however, no signage was in place to create a dementia friendly environment.

The principles of the Mental Capacity Act 2005 were not always followed.

People's needs had been assessed, however these were not always continuously reviewed.

People were cared for by staff who were trained and supported to fulfil their roles.

People were helped to eat and drink enough to maintain a balanced diet.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

We observed practice that was kind and caring but we received mixed feedback from people regarding their exchanges with staff.

People's right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were able to take in activities they enjoyed, however, this was limited to certain times of the day.

Guidance was available to staff within the care plans about how to meet each person's needs. However, these did not always include all of the information needed for person centred care planning.

People's end of life wishes were not always discussed and recorded.

Complaints were investigated in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Checks and audits were completed but had not identified the shortfalls found at this inspection.

The provider had not provided supervision or appraisals to the manager.

The views of people, their relatives and staff were obtained and used to improve the quality of the service.

Staff knew and understood their role and responsibilities.

The registered manager attended local forums to keep up to

date with best practice.

The service worked with outside agencies to provide effective support for people living at the service.

Manordene

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 October 2018 and was unannounced. Two inspectors, an Expert by Experience and a Specialist Advisor carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We asked the provider to complete a Provider Information Return (PIR) before this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We contacted the local authority safeguarding and commissioning teams for feedback before the inspection.

During our inspection we spoke with 10 people who use the service and 3 relatives. We spoke with the registered manager, 3 members of care staff and the cook. We looked at 5 peoples support plans and the associated risk assessments and guidance. We looked at a range of other records including 3 staff recruitment files, training and supervision records, staff rotas and quality assurance surveys and audits.

We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the activities that people were engaged in.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they thought the service was safe. One person told us, "I feel perfectly safe." Another told us "There is no one walking in without you knowing who they are." One staff member told us "The safety of the resident and keeping them happy and safe is my main job."

Despite these positive comments the service was not always safe. Potential risks to people's health and welfare had not been consistently assessed, staff did not always have detailed guidance to mitigate risks and people told us there were not always enough staff on duty.

Some people were living with health conditions that affected their breathing. One person's care plan had recorded that they were at risk of breathing problems due to a medical condition but did not specify what this was or how it should be managed. It also referred to breathing exercises that needed to be done but did not specify what these were or how often they needed to be done. We raised this with the registered manager and nurse who told us the breathing exercises had not been done since the person had arrived at the service. The person was new to the service and the registered manager stated they would get some further information about this and implement any necessary support. The registered manager told us that there had been no ill effect on the person because of this.

Some people used a catheter to help them manage their continence needs. Care plans for these people did not contain clear or specific information about how to maintain a catheter or signs to look for that indicated there could be a problem. Reference had been made to a technique that needed to be used but there was no further information about what this technique was. Without this information people had an increased risk of infection. The nurse on duty and staff were able to talk to us about how to care for people who needed a catheter and training had been completed. Staff told us they felt confident about looking after someone with a catheter and would recognise the signs if there was a problem. Staff told us that they would report any problems to the nurse.

The service had personal emergency evacuation plans (PEEPS) but these were lists of people's names and their next of kin details and did not contain detailed information about how to support the person in an emergency. We discussed this with the registered manager who agreed to review the PEEP's. Whilst staff told us they had received fire safety training and knew how to evacuate people safely, the lack of detail in peoples PEEPs meant staff less familiar with people would not know the appropriate procedures. Following our inspection the registered manager told us there was additional information within a grab bag and information about how to evacuate people on the doors of their bedrooms.

Failure to maintain an accurate record of care and treatment for each person using the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that the registered manager was not using a dependency tool to assist in determining staffing levels. At this inspection we found that the provider was using a dependency tool to

determine how many staff were needed each day. Based on the information that had been put into the dependency tool results indicated there were enough staff in place. This was four care staff in the morning with one nurse, three care staff and a nurse in the afternoons and two care staff and a nurse at night times.

People told us they didn't always feel that there was always enough staff. One person told us, "Half the time there isn't [enough staff], especially at night." another told us, "During the day there isn't [enough staff]." One comment from the feedback survey carried out in July 2018 said "Sometimes I wonder where they all are [staff], but I know there busy, and have to fit it all in."

During our inspection we observed staff to be rushed. During the morning of our inspection 19 people living at the service were in the lounge so staff were able to assist with their needs more easily than in the afternoon when only 10 people were in the lounge and others had returned to their bedrooms. During the afternoon we observed one person who wanted to go into the garden be told several times they would be taken out when they [staff] had finished what they needed to do. This person became agitated and continued to shout for support.

In addition to care staff there was a cleaner, cook and activities co-ordinator at the service. These staff worked until 2pm each day which meant that after this time care staff had to carry out any additional tasks. We observed staff to be busier after 2pm than in the morning.

We spoke with the registered manager about the dependency tool and its accuracy. We were told the provider completed the dependency tool and informed the registered manager of how many staff were needed.

Failure to provide a sufficient number of staff to meet peoples care and treatment needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were recruited safely. Full employment checks were completed before staff started work, including a full employment history and checking references from candidate's previous employers. Each staff member had a Disclosure and Barring Service (DBS) criminal records check in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Checks were completed to make sure nurses were appropriately registered with the Nursing and Midwifery council and were safe to practice.

People received their medicines safely. People told us they had confidence in the staff that supported them with their medication. One person told us, "I trust the staff to give me my tablets." We observed staff being patient and kind whilst giving people their medicines. One staff member told us, "We take medication very seriously, it's a big responsibility and I am very careful."

Medicines were managed safely in line with national guidance. Medicines were managed by staff who had received the relevant training and had annual assessments of their competency. Medicines were kept securely in locked trolleys and rooms and given out by trained staff. Medicine Administration Records (MAR) contained sufficient information such as photographs and allergies of each person to ensure safe administration of their medicines. MAR sheets were completed accurately and stocks we checked tallied with the balances recorded. There were checks of medicines and audits to identify any concerns and address any shortfalls. Staff followed the guidance in place on managing 'when required' medicines for each person and documented the reasons why they had administered the medicines.

People were protected from infection. The service had a policy in place and staff followed Department of

Health guidelines which helped minimise risk from infection. Staff said they had access to plenty of protective equipment like disposable gloves, and we observed staff using them. One staff member told us, "We always have enough equipment here, and we can get more if we need."

Incidents, accidents and near misses were reported by staff in line with the provider's policy, and the registered manager took steps to ensure that lessons were learned when things went wrong. The registered manager reviewed all of the incident reports on a monthly basis. When trends and patterns were identified action was taken to keep people safe. For example, one person who had fallen out of bed subsequently had falls mats placed by their bed to give them additional protection.

The garden at the service was not safe for people to use without supervision. Work had started to make this area safe and further work was planned. There were up-to-date maintenance certificates for moving and handling equipment such as hoists and baths. A recent Legionella risk assessment audit identified no risks at the service. Gas safety certificates showed appropriate checks were being made. Fire alarms and equipment were tested regularly, and escape routes were checked to make sure they were free from obstructions.

The registered manager understood their responsibility to report any safeguarding concerns, they notified the local safeguarding team when required. Staff knew how to recognise abuse and how to keep people safe. The provider had a safeguarding adult's policy and staff were aware of this. Staff understood what they needed to do to make sure people were safe from harm and potential abuse. Staff told us they received safeguarding training. Staff were aware of guidelines and contact details of the local authority safeguarding team, and this information was displayed around the service. One staff member told us, "I have done my safeguarding training and I will report anything wrong. I know what to do."

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive possible.

The registered manager had completed assessments when it appeared likely that a person lacked the necessary mental capacity to make decisions about important things that affected them. Records showed that the registered manager had involved key people in a person's life ensure that decisions made on their behalf were indeed in their best interests.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had failed to identify that DoLS applications needed to be made for people living in the service who were being deprived of their liberties. For example, bed rails were being used to stop people from getting out of bed. Risk assessments had been carried out, however, the manager had not recognised that some of these people may need to have a DoLS application completed. Doors to the garden were locked which stopped people from going out to that space. When they accessed the garden, they did this with supervision from staff at the service. We discussed this with the registered manager during the inspection who told us they would review this to ensure applications had been made for people who needed them.

Failure to comply with the Mental Capacity Act 2005 (MCA) was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection the service failed to maintain accurate and contemporaneous records in respect to each service user, this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had been made but the breach of regulation had not been met.

At the last inspection we found that pressure mattress settings were not always accurate as staff did not have the information that needed to do this. At this inspection we found that this had not changed, we checked a number of pressure mattresses to ensure they were set correctly. If they are not set correctly the impact is that people are at risk of developing pressure wounds. We found one was set well above the person weight, we checked the records and these had been signed to say it was at the correct setting. Other pressure mattresses did not have specific weight ranges on them but indicated they were set at "medium."

When we asked staff how they ensured that this was the correct setting they were unsure. There was no reference to what weight the medium setting was for.

Some people at the service had pressure wounds. The service had made appropriate referrals to the tissues viability team and the wounds were being monitored. However, we found that although guidance had been given to staff to turn people at regular intervals, and staff told us that they had been following the advice they had been given, records had not been completed to reflect this.

We spoke to staff about pressure wound care and they told us skin care was important. One staff member told us, " We always look at skin during personal care. We understand how important it is." There were skin integrity care plans in place, but these could have been more informative with the body maps including measurements of the pressure wounds so that this could be considered when the nurse looked at how it was healing.

The failure to maintain accurate and contemporaneous records in respect to each service user was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was designed to cope with most disabilities and had lifts, specialist baths, appropriate grab rails and handles, different height chairs and wheelchairs. However, there were no dementia friendly sign postings around the service and bedrooms did not have people's names on them only a room number. All doors in the service were the same colour which can make it difficult for someone living with dementia to identify where a toilet is. All floors in the service were painted the same colour which could also make it difficult for people to recognise if they were on the floor they needed to be on. The adaptation of the service did not meet with best practice for a dementia setting.

We recommend that the service seeks advice and guidance from a reputable source about adapting the environment in relation to the specialist needs of people with dementia.

The service had one communal area which was used as the lounge and the dining room. Additional tables were put up at lunch time to provide enough space for everyone to eat. All activities took place in this area. This meant that anyone who did not want to take part in an activity had to go back to their room or remain in the area this was taking place.

The registered manager had completed an assessment of people's needs prior to them moving into the service to ensure that the service was able to offer the right care and support. Further assessments of people's needs were completed when they moved in which summarised people's needs and how they wanted their support to be provided. These included assessments around nutrition and hydration, risk of falls and mental capacity. These were reviewed regularly to identify any changes in people's needs.

The registered manager had a plan in place for staff supervision sessions for the remainder of the year. We saw the supervision and appraisal matrix which recorded when supervision sessions for staff had taken place. Staff told us they did receive supervision and felt supported by the manager.

People received care from staff that were effective in their roles. Staff received a range of training and support relevant to their role. Staff told us they had the training and skills they needed to meet people needs. They told us that training was updated yearly and they were able to ask if there was any training that they feel they needed. Since the last inspection staff had received additional training in subjects such as dementia care, tissue viability and pressure area care and end of life care.

Staff told us they received a handover at the start of each shift. This gave them information they needed about changes to people's needs or conditions. It included details about who needed assistance to change position frequently and who needed encouragement to eat and drink.

People were supported to have enough to eat and drink and maintain a healthy diet. There were people living with dementia at the service who would benefit from seeing food before they made choices. While we did observed staff asking people what they would like to eat and offering them choice, picture menus were not available which may have helped people to make informed choices. This is an area we have identified for improvement.

People told us they had enough to eat and were offered drinks and snacks throughout the day. Risks associated with people's ability to eat and drink or special diets they needed had been assessed and were followed by staff. We saw staff completed monitoring charts of people's food and fluid intake where needed. The nursing staff and the manager kept these under review and if people were not drinking enough throughout the day staff were informed to encourage people to drink more. This helped to ensure people were kept hydrated and received sufficient nutrition.

The cook was aware of people's likes and dislikes, and dietary needs and they explained how they boosted people's meals if they needed extra calories to gain weight and remain healthy.

Staff asked people for people's consent before supporting them with their care and support. One person told us, "They always tell me what they are doing and ask if its ok."

People's health and wellbeing was maintained and reviewed in partnership with external health services. People received home visits from health professionals and were supported by staff to attend hospital appointments. Staff told us that specialist health professionals visited to provide support around a specific health condition. For example, the tissue viability team visited a person who had a pressure wound. The registered manager told us that relationships with health care professionals such as GP's were good.

Requires Improvement

Is the service caring?

Our findings

During our inspection we saw a mix of positive and neutral interactions from staff towards people, with a significant amount of interactions being task focused. During our inspection we observed that on most occasions care staff were kind and considerate, however, we also observed occasions where some care staff were blunt and unhelpful in their manner. For example, we saw one staff member continually tell one person to "sit down" and then dismiss someone who was upset. We spoke to the registered manager about this, who said they would highlight the concern with all staff at the next staff meeting and during upcoming supervisions. The registered manager confirmed that this had taken place following the inspection.

We found people had differing experiences about the care they felt they received. While some people were positive about the care they received, others were not. Most people told us staff were caring towards them. One person said staff were "Very kind." however, another person told us, "They are sometimes, if they are not too busy."

People's dignity was not always respected or promoted by staff. We saw one person in bed with their bedroom door open, this person's dignity was compromised as part of their body was not covered. We spoke to the nurse and they went into the room and covered the person up. Staff must ensure people's dignity is promoted at all times. This is an area we have identified as requiring improvement.

Staff knew people well and had built good relationships with them. People were called by their preferred name and this information was available for staff to refer to in each person's care plan. People's rooms were personalised with their own possessions, they had their own things around them, which were important to them. One staff member told us, "We never stop, but we don't rush people."

Some people preferred to remain in their rooms while others liked to be in the communal lounge or dining room. Staff respected their decisions and made sure people in their rooms were checked regularly to see if they needed assistance.

Some people needed assistance when eating their meals; we observed staff to be attentive and patient. Staff encouraged people to eat their meal; they did not rush or hurry people. However, we witnessed staff members stood in the dining area during lunch talking to one another rather than taking to time to talk to people.

People privacy was respected; doors were closed when people received personal care. People's confidential information was stored securely and could be located when needed. This meant that confidentiality was maintained as only people authorised to look at records could view them. One person told us, "They certainly respect your privacy. They don't rush in."

People were supported with any individual beliefs and people from the local church visited on a regular basis. During our inspection we saw people taking part in a harvest festival celebration.

People who needed support to share their views were supported by their families, solicitor or their care manager. The management team knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Information was displayed around the service but not all had been displayed in a way that people with dementia or a disability were able to understand. Staff we spoke to were not aware of AIS and there were no plans in place for this information to be provided.

We recommend the service seeks advice and guidance from a reputable source regarding providing information to people in a way they understand and which complies with the Accessible Information Standard.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 4 and 7 August we found the service failed to ensure that people had a range of meaningful activities that were tailored to their interests which was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found the provider had taken steps to meet the breach of Regulation 9 relating to activities, however, we found a further breach to Regulation 9 in relation to care plans.

The provider had put a plan in place to improve activities following our last inspection. An activities coordinator had been employed and worked four days each week for five hours each day. People living at the service had been asked about activities they wanted to do and this information was in each person's care plan. During our inspection the activity of the day was a harvest festival. People were engaged in the activity.

The service was taking part in a music therapy pilot project funded by a local hospice. A music therapist visited the service to do ten one to one sessions with three people who were at risk of isolation. The registered manager stated that the people involved were, "Really enjoying and benefiting from the therapy and we are starting to see a lift in their mood."

Through discussion and observation, we found the activities coordinator to be highly motivated and keen to learn. However, we observed that after the activities coordinator had left, people did not engage in meaningful activities and they watched television in the lounge for most of the afternoon. People's mood within the service appeared to lower and we observed people becoming agitated. This has been identified as an ongoing area for improvement.

Some people living with diabetes were being supported daily by the nurse to monitor and administer their insulin. There were generic guidelines in their care plan to assist staff to recognise when a person may need medical attention if their blood sugar was too high or low. However, the care plans did not record what a normal range of blood sugar was for the individual person so that staff understood what would be acceptable for that person. The nurse on duty and staff were able to talk to us about how to care for people with diabetes and training had been completed. Staff told us they felt confident about looking after someone with diabetes and the chef told us about the dietary requirements for someone with diabetes.

The failure to ensure care plans were person centred with regard to diabetic care was a breach of Regulation 9 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

People received the care and support they needed to keep them comfortable at the end of their life, however staff did not routinely record what people wanted to happen at the end of their lives. Some people were living with dementia and others were frail. All people living at the service needed nursing care. There was a risk that people's need may deteriorate unexpectedly and without a clear record of what they would like to happen at the end of their life, their wishes may not be respected. The registered manager told us that they recognised that end of life care planning should be started as soon as possible. However, many people

and their families did not like to discuss end of life care, but staff would ask about end of life care when people were admitted.

We recommend that the service seek advice and guidance from a reputable source, about the management of end of life care.

When people were at the end of their lives they had access to a range of pain relief medicine to help them remain as comfortable as possible. Nursing staff had been trained to administer this medicine, to ensure that it was given safely. Staff had taken part in a range of training with the local hospice. The hospice visited the service on a regular basis to help nurses to support people who were at the end of their lives.

Peoples care was based around their needs and choices and people and their relatives were involved in planning their care. Guidance about how to provide people's care was available to staff in people's care plans. Care plans included information on a range of area including mobility, communication, food and drink and likes and dislikes. Staff knew the support people needed and how they liked their care provided. Care plans had been reviewed regularly by staff; when people's need changed, this was reassessed. Where people were not able to be involved in these reviews, records showed that care had been discussed with relatives and professionals and where appropriate best interest decisions had been made.

We looked at how the provider managed complaints. There was a complaints procedure in place. People and relatives told us they knew how to raise a concern or make a complaint. Complaints received had been acknowledged and investigated. People who had made complaints were informed about how their complaint had been investigated and the outcome of the investigations. Everyone was satisfied with the response they received. There was a copy of the complaints policy on the noticeboard in the entrance hall of the service.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. The registered manager was visible in and around the home, staff found them approachable and felt they were supported by them.

At our last inspection on 4 and 9 August 2017 we found that the registered provider had not ensured that quality monitoring was effective in highlighting shortfalls in the service. This was a breach of Regulation 17of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At this inspection we found some improvement to the quality monitoring of the service. The registered manager was completing a number of audits to measure the quality of care and support being provided at the service. The audits looked at accidents and incidents, infection control, medication, catering, cleaning and care plan reviews. However, the audits did not pick up all the recording issues we identified during our inspection in relation to, for example, PEEPS and catheter care. This meant the registered manager did not always have a clear picture of the service or improvements that needed to be made. The registered manager was not aware of shortfalls we found in turning charts or pressure mattress checks. This meant that people at risk of pressure wounds were not always monitored effectively. We also found that not all of the weekly checks had been carried out and the registered manager was not aware of this. For example, there were gaps in the water temperature testing and medication room temperature. The manager was unable to find these. This demonstrated that the registered manager did not have effective oversight of the service.

Where the audits did pick up issues the registered manager arranged for improvements to be made. For example, the infection control audits highlighted areas for improvement. The deputy manager planned to attend training to drive change in this area.

We found that the provider's quality monitoring system had failed to identify and address the issues which we found during this inspection. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to provide the registered manager with one to one supervision meetings or an annual appraisal. The registered manager did not have a formal way of being supported or identifying if training could be provided to support their role. There were no plans in place for the continuous development of the registered manager. We discussed this with the registered manager who expressed that they would benefit and develop as a manager with supervision. We identified this as an area requiring improvement.

There was an open and transparent culture, the registered manager told us they had an open door policy, staff told us they could speak to them whenever they wanted. One staff member told us, "She [the registered manager] is approachable. I can talk to her if needed."

The registered manager attended local forums and groups to improve their knowledge about best practice. The registered manager told us this allowed her to network with other managers and access information

that could be passed onto staff and included in working practices.

The registered manager worked with local agencies, including the local safeguarding authority and tissue viability nurses. The service was working with the Clinical Commissioning Group (CCG) on a winter pressures initiative which identified people who may be better cared for in residential nursing care rather than hospital.

The service continued to promote a positive culture that was person-centred, open and inclusive. The registered manager told us the ethos of the service was holistic and person centred care and stated, "This is their home and we try and make it that for them as much as we can."

Residents meetings were held every couple of months. The registered manager reminded people and staff that they had an open door policy and they could be contacted with any concerns comments or suggestions. People had made suggestions and these had been actioned. For example, people had asked for certain activities to be thought about. The registered manager and activities co-ordinator were looking into different activities that could be provided for people living at the service.

Staff meetings were held every eight weeks, however, the registered manager told us that not all staff attended these and it was not compulsory for staff to attend. The manager told us that the minutes of these meetings were made available to all staff after the meeting and they were asked to sign to say they had read them.

People, relatives and staff had the opportunity to provide feedback about the service. People living at the service had been given a survey in July 2018 and this had been summarised. The surveys identified that people wanted to be able to use the garden more. Work had started on the garden to make it safe for people to use and this work was ongoing. We observed people being taken outside.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. The provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance. They were aware of the statutory Duty of Candour which aimed to ensure that providers were open, honest and transparent with people and others in relation to care and support.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall. The service did not have a website.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that each person has an accurate and personalised plan which reflected their individual needs and preferences. Regulation 9 (1) (3) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality of the service; to assess, monitor and mitigate risk and to maintain accurate and complete records for each service user. Regulation 17 (1) (2) (a), (b), (c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure that there were sufficient staff to meet people's

care and treatment needs.

Regulation 18 (1)