Edgbaston Healthcare Limited

Melville House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 22 and 28 March 2018.

Melville House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Melville House accommodates up to 29 people providing residential and nursing services and a service for people living with dementia. At the time of our inspection 27 people were living at the home.

At the time of this inspection there had been no registered manager in post for a number of months as the former manager had not applied to become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was aware as part of their registration a registered manager was required to be in post. The provider had recruited to the post of manager however they had not commenced their employment at the time of this inspection.

At the previous inspection on the 27 April 2017 the provider had an overall rating of requires improvement. At this inspection the overall rating has remained at requires improvement .This is the fifth consecutive inspection where the rating has been requires improvement.

The provider's quality checking arrangements were not consistently strong and effective in identifying, making and sustaining improvements in the quality of care people received. Managerial changes together with the lapse in the provider's checking procedures had led to inconsistency in leadership. This had impacted on aspects of the quality of care to support people in receiving safe, effective and responsive care which was well led.

There were inconsistencies in the provider's systems and staff practices to provide assurances that all risks to people were safely and effectively managed. Some risks to people's health and safety were not well managed which included monitoring people's weight loss, administration of medicine and reducing risks of fire hazards.

Staff and the provider knew how to report allegations of abuse. However, we identified an occasion when the provider had not made sure an incident of abuse had been reported to the local authority or ourselves. Staff reported accidents and incidents however the management team did not review them to ensure appropriate action had been taken and to reduce the risk of incidents happening again.

Staff understood the principles of infection prevention and control. These principles were not always embedded in staff's everyday practices to reduce the risk of cross infections and to support people to live in

a pleasant home. The provider had an on-going refurbishment plan but there was more to do in supporting people to live in a pleasant home where facilities met their needs.

People's care records did not consistently hold the information to guide staff practices to support people to receive individualised care. Staff did not always explore how they could support people to live the lives of their choosing. There were on-going improvements in order to offer people a broad range of things to do for fun and interest.

People were confident there were enough staff to meet their needs safely. Staff were available to respond to people who needed reassurance to improve their well-being.

Appropriate checks had been completed for new staff to ensure they were safe to support people who lived at the home with their care needs. The training provided for staff was not consistently embedded in staff practices and there was no regular oversight of where improvements were required to support staff to be as effective as they could be.

People were supported to see, when needed, health care professionals. Staff recognised changes to people's physical well-being and relatives said they were kept well informed by staff regarding their family member's health and well-being. The management and oversight of people's medicines required improvement. People were supported with their meals, where needed, Some people believed they would benefit from more areas to eat their meals and dining tables to enhance their pleasure at meal times.

We saw that staff obtained people's consent before providing care to them. Where people could not consent, assessments to ensure decisions were made in people's best interest had been completed. Staff had variable knowledge about where people had authorisations in place to ensure people had the care and support they required and any restrictions were lawful.

Staff were caring however we saw some practices were focussed on tasks rather than providing individualised care. When staff did communicate with people we saw examples of kind care, with staff showing affection and compassion towards people. People were supported to maintain relationships which were important to them.

We found three breaches of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The risks to some people's safety were not always assessed to reflect their current needs and there were inconsistencies in how staff would mitigate these. People's medicines were made available and staff had received training to administer these. People could be assured staff had the knowledge needed to minimise the risk of abuse but the provider's systems to oversee these was not effective. People were confident there was enough staff to provide care and support safely. Staff understood how to reduce the risks of cross infections but did not always ensure their knowledge was applied in practice.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who did not always reflect their skills and knowledge into their caring roles so people's needs were effectively met. Staff reflected inconsistent understanding about where people had lawful restrictions in place to support people to receive the care they required. People had food which they mostly enjoyed. However improvements were required to make sure people's individual food preferences were effectively catered for. Work was on-going to refurbish the home environment however further thought was required to make sure it met people's diverse needs. Staff knew how to assist people in making everyday choices. People were confident staff supported them to contact different healthcare professionals should they need treatment to keep them healthy and well.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some of the care practices were focussed on tasks. Thought and consideration had not always been applied on a daily basis to the facilities to support people's dignity and independence. People felt staff had caring natures and knew them well. Staff understood the need to maintain the confidentiality of people's personal information.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records did not always provide staff with guidance and information to support the consistency of how people's individual needs were responded to and met. Improvements were on-going to support people to follow their interests and provide opportunities to meet the needs of people with dementia, so risks to people's need for stimulation was reduced. There was a system in place to make sure any concerns or complaints raised with the provider could be responded to in the right way.

Is the service well-led?

Requires Improvement

The service was not well led.

There were ineffective systems in place to monitor the quality of care provided and keep people safe. A lack of environmental safety checks potentially put people's safety at risk. Systems in place did not guide staff to ensure good practice was consistently provided. The provider had not conducted thorough quality checks of the service to assure themselves people received good quality care which was safe, effective and responsive. People were positive about how staff were caring when supporting them and staff felt they worked as a team.

Melville House

Detailed findings

Background to this inspection

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

The inspection visit took place on 22 and 28 March 2018 and was unannounced. The inspection was undertaken by three inspectors, a special advisor and an expert-by-experience on the first day. The specialist advisor was a registered nurse. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service. Two inspectors returned on the second day which was unannounced.

We brought the inspection visit forward as we had received a numbers of concerns about the management of the services provided to people and the quality of aspects of staff practices to ensure people remained safe and well cared for. During the planning and conducting of this inspection we took into consideration the concerns we had received, together with the information we received from the provider about the service. This included events which we had been notified about, such as any serious injuries to people.

In addition, we asked various organisations who funded and monitored the quality of the care people received, such as the local authority and clinical commissioning group. We also sought information from Healthwatch who are an independent consumer champion, which promotes the views and experiences of people who use health and social care.

We spoke with seven people and one visitor about what it was like to live at the home. In addition, we spoke with three relatives by telephone. We looked at six people's care including sampling their care and monitoring records to see how their care and treatment was planned and provided. We spent time in the communal areas of the home with people who lived there and saw the care and support provided by staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with four care staff members, one nurse, assistant manager and a cook about their roles and what

it was like to work at the home. We also spoke with the maintenance person. The provider spoke about their role and their oversight of different aspects of the services. In addition we spoke with a visiting professional during our inspection.

We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We looked at the results of the provider's quality checking and monitoring arrangements to see what actions were taken and planned to improve the quality of the services provided. This included the recording and analysis of accidents and incidents, complaints and meetings with staff.

Following this inspection, we requested information from the provider to ensure they had reported an incident of abuse to the local authority and reduced the risks to people living at the home. In addition, the provider sent us information which included a report from their electronic medicine system which showed a day's administration of people's medicines.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in April 2017 we found improvements were required as there were insufficient numbers of staff to ensure people were safe. At this inspection staff were available to respond to people who needed reassurance to improve their well-being. However, improvements continued to be required to reduce risks to people's safety. The rating continues to be requires improvement.

Staff we spoke with understood the provider's arrangements for reporting accidents and incidents which included what constituted abuse or poor practice. One staff member told us, "Abuse could be neglect, unexplained bruising or self-harm. I have a duty to keep people safe." Staff had completed training in abuse and knew what they should do if they had any concerns about people's safety or they suspected abuse. Another staff member said, "The nurse would follow through any incidents of abuse."

However, we found a senior staff member had not reported an incident of abuse at the time it happened to the local authority and the Care Quality Commission as required. At the time of this incident in February 2018 senior staff had also failed to complete a written risk assessment of how the person was supported to promote their welfare and maintain the safety of other people. Although, we saw no evidence that this omission had impacted on people's safety the provider's systems had not been effective in assisting them to have an oversight of incidents. This was because there had been a lapse in the provider's systems being completed which did not support the provider in assuring themselves of the safety of people in their care.

People were at potential risk of harm because risks to people's health and safety were not always assessed with the outcomes from this fully detailed in their care records. We saw the risks to support a person in doing something they enjoyed had not been fully detailed in their care records to guide and support consistent staff practices. For example there was no risk management strategy to reflect how the person's needs were supported whilst minimising risks to their safety and other people's from the hazards of fire. This was particularly important as staff were aware the person did not always comply with the provider's procedures to reduce the risk of fire and keep people safe. However, the provider had not assured themselves that the person's individual needs and risks were accurately assessed and recorded together with how these were consistently monitored.

There were aspects of staff practices which were inconsistent in mitigating the risks to people's safety, health and welfare. For example, a person was taking their own medicine which was also administered to them by staff during the medicine rounds. Therefore there was a potential this person was receiving more medicine than prescribed which put their health and well-being at risk of harm. There was no risk assessment in place to show how this person was supported to take their own medicines and to mitigate the risk of the person taking more than the prescribed doses of their medicine. When we identified the risk to staff they immediately made contact with the person's doctor to take advice and removed the medicine from the person.

In another example the provider's nutritional monitoring processes noted two people required their weights to be checked weekly, with referrals made to their doctor for food supplements. However, we saw these

actions had not been consistently undertaken. The senior staff member showed us documentation which reflected referrals had not been made to the doctor until two months after it was noted this action was required and both people sustained weight losses. This showed the plans to manage some people's risks were not always followed to promote their safety. In addition, the provider's systems were ineffective in identifying when actions had not been taken to manage risks to people in a timely way so their safety was not compromised.

The provider and a senior staff member were unable to explain why action had not been taken in line with the information contained in the nutritional checks. The provider told us senior staff had the responsibility to monitor people's weights. This included completing the nutritional checks; they said they would make sure these inconsistencies were addressed.

Staff we spoke with confirmed they had received training in infection control and could tell us how they worked to reduce the risk of infection. For example, staff described to us how when they provided personal care to people they wore protective clothing. We saw this was the case as staff wore disposable gloves and aprons. Staff also wore protective clothing when handling food.

However, we saw some infection prevention and control practices which fell short of the required standards and did not reflect staff had consistently incorporated their knowledge into everyday practices. For instance, there was a variety of toiletries in an unlocked cabinet in a communal shower and toilet area with no indication of whom they belonged to. Staff were aware these practices placed people at risk of infection due to potential cross contamination. However, staff we spoke with were unable to provide reasons as to why these toiletries were left in communal areas and recognised it did not reflect all staff had put their knowledge into their everyday caring roles.

All of the above shows the provider had not consistently ensured risks to people were identified, monitored and that guidance was in place, and staff followed the guidance. We found this was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We saw examples, where staff were aware of the risks to people and managed them safely. For example, one person required particular assistance to meet their catheter care needs. From speaking with the community nurse and staff we were provided with information which showed staff knew how to manage the risks to this person. Another example was how people had beds which supported their individual needs so their safety was maintained. Where people were assessed as requiring bedrails these were in place so people were not at risk of falling out of bed. One person indicated they felt safe with their bedrails in place.

People we spoke with told us they felt safe with the support staff provided. One person told us, "I like living here, and I feel safe." Another person said, "I feel safe here, if I didn't I would speak to my family." A person's friend commented, "I think she is safe here, I think that she is safe in their [staff] hands."

The provider had taken measures to reduce the impact of unexpected events. For example, there was a fire procedure on display in communal area. This provided information for people and their visitors on what they should do in the event of a fire. One staff member said, "If we hear the alarm we know what to do and we reassure people." Another staff member was clear on where people were required to go outside of the building in the event of a fire. Personal evacuation plans were available to staff so it was clear what support people would need to evacuate the building if this was necessary.

People we spoke with told us their medicines were made available and they were supported by staff to take these. One person told us, "They give me medication; they make sure I take it." Another person said, "They

[staff] would give me something if I was in pain." A further person said they did receive their medicine however staff were late in doing this at times.

We observed a staff member during a medicine round. We saw the staff member explained to people what their medicines were and gave reassurance when this was needed. A person declined their medicine which was respected by the staff member who said they would return later to check whether the person required their medicine. The staff member used safety measures when storing and administering people's medicines. These included making sure the medicine trolley was locked when unattended between taking medicines to people.

We received varied responses when we asked people about the availability of staff to meet their needs. One person told us, "I don't know if there is enough staff, but everyone gets looked after." Another person said, "I don't mind it here, you can always speak to people, there is always someone around."
The provider confirmed staffing levels was based on meeting people's individual needs. When speaking with staff about this subject they had no concerns about staffing numbers not being adequate to meet people's individual needs safely. We saw staff had time to meet people's care and support needs, without rushing. For example, we saw individual staff members assisting people to move from different areas of the home as they chose.

People were supported by staff who had received appropriate checks prior to them starting work. We spoke with a staff member about the checks that had been done prior to them starting work at the home. They confirmed the management had requested their previous employers to provide references for them. They told us they had not been allowed to start work until criminal checks on their background had been completed to ensure they were suitable to work with people who lived at the home. These checks are called disclosure and barring service checks.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in April 2017 the provider was required to make improvements to ensure people's rights to giving consent to aspects of care were made by people who had the authority to do so. At this inspection we identified more could be done to effectively support people's particular needs and the rating remains as requires improvement.

We found training was not consistently embedded into aspects of staff's practices. For example, we saw a staff member did not wash their hands before supporting a person with their eye drops. Another example was how a staff member did not sheath a needle before placing this into a sharps bin, [this is a bin for the disposal of needles], the nurse did not hold the insulin needle in for ten seconds after use according to best practice. The provider's quality monitoring did not reflect they had processes in place to check the competency of staff following their training to assure themselves staff were effective in their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When an assessment shows a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

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 provider had ensured applications had been submitted under DoLS where this was required. However, staff had mixed knowledge about what DoLS meant in terms of their caring practices. Staff we spoke with were not always able to confirm the basics of the DoLS to ensure their practices were effective in maintaining people's rights. For example, a staff member was able to tell us where people may have possible restrictions in place, such as bedrails and where people would be unsafe to go out alone. However, they did not know who had a DoLS in place which is important knowledge to make sure people were not being restricted unlawfully. Although we did not see any staff practices where people were restricted unlawfully, the provider would take action to ensure all staff had reminders about DoL training they had undertaken. In addition, staff would be reminded in meetings about people who had a DoLS in place so staff had this important knowledge to make sure people were not being restricted unlawfully.

People's records confirmed decision specific capacity assessments had been completed and best interests decisions had been made where people did not have capacity. For example, where a person required medicine to meet their health needs a specific decision was made for this to be administered covertly [disguised in food].

People told us how staff gained their consent in everyday practice. One person told us, "I get up and choose what time I go to bed." Another person said, "The staff do ask consent to assist me and they respect me."

Staff practices showed they understood the principles of the MCA when supporting people to make choices and decisions. For example, staff asked a person before they assisted them with their physical needs. Another person was asked if they would like to go to their room. In addition, we saw staff used various ways of assisting people to express their wishes which included knowing people well enough to understand their body language and facial expressions. One example was how staff considered a person's facial expressions and body language to determine the support they required to feel more reassured.

Although the provider had a programme of redecoration we saw the home environment looked tired and in particular there was a lack of signage. For example, there was signage on a door to inform people the door opened into a specific area which was not the case. We discussed this with a staff member who acknowledged it could be confusing for people and did not reliably assist people to orientate themselves. However, staff told us they supported people to move around their home when this was required and people knew their home environment having lived there for a period of time. We saw some effort had gone into placing items of interest on some walls for people to enjoy which was acknowledged by a staff member.

People gave us various responses about their views on the food they were offered. Comments included, "The food is good, and we have a choice" and "I don't eat food sometimes, they need a good cook." We saw staff provided the support people needed whilst they ate their meals. We also saw there were limited opportunities for people to have their meals at dining tables. There were not enough dining tables and chairs in the two lounges so all people could choose to have their meals at tables. When we asked staff about this they told us people preferred to have their meals where they were sitting. This did not correspond to some people's comments, as one person told us, "We could do with a proper dining room" and another person said they would like to have the option to sometimes sit at a dining table with others if there were more tables.

The cook was able to tell us how they catered for people's individual nutritional needs and how everybody had the same opportunities to enjoy varying food options. For example, people with diabetes had options of desserts which were made to meet their health needs. Despite the cook obtaining people's food preferences some of the catering arrangements did not always support people to enjoy their meals. We heard examples of how people would value more food variety to meet their particular tastes and preferences. The cook told us they were continually reviewing the meals offered with people and would ensure further options were explored with people based on their preferences and cultural needs.

Staff told us when they had started work at the home they received an induction which helped people who lived at the home to become familiar with them. Shadowing experienced staff was also part of the induction training along with the completion of the care certificate. The care certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. One staff member said their induction alongside the training they received assisted them to learn about their roles and responsibilities.

People we spoke with were confident staff knew how to provide them with the practical assistance they needed. One person said, "The staff help me to do exercises, and I feel safe when they hoist me." Another person told us, "I think that the staff know their job." In addition, people we spoke with told us they were supported with their health needs. One person told us, "I see the doctor, chiropodist and other professionals when or if I need them." Another person told us, the doctor visited the home regularly and staff would arrange for them to see the doctor if they wanted to. A further person commented, "The staff take me to my appointments for my eyes."

Relatives were also confident staff had the knowledge and skills they needed. One relative said, "I'm completely confident in the staff because when I ask something about my family member's care they all seem to know what's what." Additionally, relatives were appreciative of how staff supported their family member's with their health and wellbeing needs. A relative told us, "I have no worries about how [person's name] health is reviewed by the staff and I am very reassured by staff who I know would get the doctor or call for an ambulance if this was needed without any delay." During this inspection a community nurse visited who was confident staff would contact them to ensure the person's needs were effectively met.

Requires Improvement

Is the service caring?

Our findings

As at our previous inspection in April 2017, we saw staff treated people with warmth and kindness and the rating was good. At this inspection we saw there was not always a personalised approach taken when supporting people. The rating has changed to requires improvement.

The provider had not made sure they led by example to assure themselves people were provided with high quality care so this ethos was firmly rooted in their oversight and quality checks to enrich people's care experiences. For example, there were elements of the facilities in the home which did not support people's dignity and independence. In one example a tap in a communal area was loose so as the tap was turned on, hot water was directed onto the sink and floor area. Staff told us people did use this room however there was no evidence as to whether staff had reported the fault with the tap so this could be repaired in a timely way. In the same room a shower curtain was torn in many places which did not reflect consideration had been given to how this respected people's dignity. The provider was unaware of these areas which needed attention until we raised them and gave us assurances they would take action so these faults would be repaired.

In addition, we heard comments from a relative who told us there were not enough chairs and or communal space to sit with their family member when they visited. During our inspection we saw the communal lounge areas looked cramped when people occupied these. One person told us, "There is not enough space in the lounge, I have a walker but cannot use it as there is not enough space to walk or get it through the door." We discussed with staff the reason a communal room on the ground floor was no longer in use as this had been at our previous inspection. We received various comments which included it was going to be redecorated. On the second day of this inspection the provider ensured the room was able to be used again by people, for example we saw a person eating their meal in there.

Some staff were more skilled than others at keeping people at the centre of all their care. For example, one staff member checked if they could assist with cutting up food to help a person eat independently. In contrast on another day, another staff member cut up the person's food without checking if this was acceptable to them. Some staff took time to explain what the meal was and others did not.

People gave us varied views on how staff took a caring approach to supporting them with their individual needs. For example people felt the food to meet their individual preferences and cultural needs could be improved. People's comments included, "I have never been asked if I would like Caribbean food, I would love some" and "I would like some Caribbean food, I would love some cornmeal porridge." Additionally, a relative told us how their family member would appreciate food to meet their cultural needs.

Despite the inconsistencies in staff practices about maintaining a personalised approach people spoke positively about staff. People felt staff were caring and treated them or their family member well. One person said, "Staff are good to me." Another person told us, "I can have a shower or bath when I want." A further person said, "I can go to the shops when I like, as long as I let them know when and where I am going, I go once or twice per week." Relatives we spoke with were similarly positive about how caring staff were.

One relative commented, "Staff are very friendly and helpful, [family member] gets on well with staff." A friend said, "The staff is so caring, couldn't ask for any better. That is why she remains here; they are very good and respect her."

Staff told us and we saw when people invited us into their personal rooms they had photographs of family and/or older photographs of themselves at a younger age. This gave staff a point of reference for conversation and gave people a sense of identity. We heard staff spoke with a person who lived at the home about an important person in their life which showed staff valued people's own identity. Additionally, we heard from staff how they read religious material with people at their request to support people to maintain their diverse religious and spiritual needs. One person told us, "The priest comes regularly to administer Holy Communion."

Most people looked relaxed in their surroundings and chatted to staff as they passed by them in corridors. A number of people chatted and joked with staff showing they felt at ease in their home. We saw some examples whereby people's welfare was improved by the caring nature of staff. One example was how a staff member went to fetch a person a cardigan as they had noticed they were cold. We saw through the facial expressions and body language of the person they valued the staff members consideration of their welfare.

We heard some positive examples from people about their experiences of staff respecting their privacy. One person described how they preferred to spend time in their room as it allowed them, "A little privacy as I like some time on my own." We saw staff respected this person's wishes. Another person told us, "The staff knock my door before entering even if I am not in there." Staff were seen to knock on people's personal doors before entering and closed the door before supporting the person with their personal care.

People who lived at the home and relatives were positive about how staff always welcomed them. One person told us, "Visitors welcome and offered a drink." One person's relative said there had never been any restriction on visiting. They gave us an example: "I can turn up at the home at any time and staff welcome me." Another relative said, "Relatives really made welcome and can have a drink if they want one."

Staff had access to local advocacy services and would use this to support people if they required independent assistance to express their wishes. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

The provider's arrangements ensured private information was kept confidential. We saw written records which contained private information were stored securely when not in use.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in April 2017 the provider was required to make improvements to ensure people consistently had opportunities to take part in activities which met their individual needs and the home environment was suitable for people with dementia. At this inspection people's records lacked details to provide staff with guidance when responding to people's individual needs. In addition, we found more could be done to respond to people's needs in a personalised way taking into account their preferred choices and wishes. The rating remains at requires improvement.

We looked at care records and found inconsistencies in the accuracy of the information provided for staff in people's care plans. For example, one person had significant health concerns and we saw they had been attended to. However, this person's care records lacked detail about the signs and symptoms a person may experience which could be an indicator of their health deteriorating. In another example we saw there were insufficient details in outlining measures to support a person with their behaviour, such as known triggers so the person was assisted in the best possible way for them. In addition, there were no charts for staff to use for the purpose of monitoring the person's behaviour, as another form of guidance for staff to consider when deciding about further specialist support for the person. Although staff were able to tell us about both people's needs they did not have the relevant documented information to make sure each person's needs were responded to in a consistent way. In addition there was a risk relevant information was not captured for use by new staff and professionals or provided sufficient evidence to show appropriate care was being provided and delivered.

A personalised approach to considering people's preferences and independence was not always taken when responding to aspects of people's care. For example, a person liked to take some of their own medicines which they were doing without staff's knowledge. However, when this was identified during our inspection staff removed one of the medicines from the person. Although staff did this with the best intentions they failed to set time aside to assess the person's own preferred choices to reflect a personalised approach was taken to support the person with their needs.

We found more could be done to support people from different cultural backgrounds who lived at the home. For example, we saw there was a reliance on some staff who spoke a certain language to communicate with a person who lived at the home. However, there was no information in accessible formats to support staff when staff who could speak a person's language were away from work. Staff told us they used visual clues such as different gestures, such as pointing at cups to see if a person would like a drink. We saw staff used these gestures during our inspection and the person reacted to these. However we had no assurances without information being accessible to all staff whether this was the case with other aspects of the person's needs, such as personal care.

We received varied comments from people about how staff responded to their needs in ways they liked. One person told us, "They know me well enough and what I like." Another person said, "I am able to have a shower when I want to." A further person suggested there could be more options of fresh food to support their health needs although they did like the food offered." Another person told us, "I am told to just sit

down and watch television it is not good, I am not happy." In the care plans we looked at we saw detail was lacking about people's individual preferences and interests, and did not include details of people's life histories. Staff we spoke with knew about the needs of people because they said they had worked with them for a long time.

Despite the inconsistencies in care records, staff told us they had an opportunity to catch up with any changes to people's health or care needs. This was because they had verbal exchanges with each other and a handover of information when shifts changed. One staff member said, "Changes are talked about at handovers and we talk to each other."

We heard from people they were supported to do the things they enjoyed. One person told us, "We go out into the garden when the weather is okay." Another person said, "I do enjoy listening to a bit of singing, cheers me up." A relative told us they thought there could be more activities to help to stimulate people and keep them well, such as doing exercises. We saw different things for people to participate in during our inspection which included singing and the activities coordinator having conversations on an individual basis with people. We heard from staff how they supported people to visit different places they liked to go, such as shops, banks and the botanical gardens. One person told us staff supported them to go to the shops and another person said, "They [staff] have gone with me to the shops."

We spoke with the activities coordinator who was enthusiastic about their role in supporting people to have fun and interesting things to do. The activities coordinator told us they wanted to continue to broaden the range of activities offered. The provider said they were committed in supporting the activities coordinator in this venture. The activities coordinator described to us how they involved people in doing things they enjoyed linked to people's lives. One example was how a person who liked to sew was supported to darn a sock because there was a hole in it. The person did this with staff support to thread the needle.

The activities coordinator was aware they needed to further improve the activities for people with dementia and told us they were committed in doing this. This was an area we identified where improvements were needed at our previous inspection. However, the activities coordinator was able to tell and show us the plans they had to drive through further improvements in the range of activities to meet people's needs. The activities coordinator also said the former manager had encouraged them to undertake an activity leadership course which was valuable in developing their role and knowledge to support people's sense of wellbeing. We will look at how the provider has supported the on-going developments in responding to people's diverse needs with things to capture people's interest and provide fun at our next inspection.

People told us they had not been involved in meetings at the home in the past. However one person said, "I have never been to any meetings, there is a comments box and you can fill in cards." Another person commented, "We sometimes fill in survey forms and questionnaires." The results from people who had completed questionnaires were unable to be found. This meant we could not see the provider's response to people's views about the quality of the services they received and whether people had made any suggestions for improvements. However, people who lived at the home said staff and the provider were approachable and would resolve any issues they had. For example, a person told us repair work had taken place in a timely way so they were able to have a bath as this was their preference.

At the time of our inspection there was no one receiving end of life care, staff told us they had provided end of life care to people if the home was their preferred place of death and their needs could be met. We asked staff what they thought was important in terms of care and support for people near the end of their lives. One staff member described to us how they made sure people were as comfortable as possible and were provided with reassurance when needed. Another staff member talking about providing care for a person

with end of life care needs to, "Make them [people who lived at the home] comfortable."

People told us they knew how to raise complaints or concerns if they wanted to. One person said, "I don't have any concerns or complaints." Another person said, "I know how to and would complain if I had to." Staff told us they supported people and relatives to raise complaints or concerns if they wanted. We saw a record of one complaint raised which showed they were responded to and resolved in line with the provider's complaints procedures. The provider's complaints procedures were accessible to people who lived at the home and visitors.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in April 2017, we found the provider did not have an oversight of the quality monitoring checks undertaken by the former acting manager. The rating was requires improvement. At this inspection, we found the quality checking systems were ineffective in supporting people's safety and welfare. The rating continues to be requires improvement.

At the time of our previous inspection in April 2017 the provider had been without a registered manager for over six months and the current acting manager told us they were in the process of applying to become the registered manager. However, at this inspection we found there had been changes in the management of the home. The former acting manager had left their post at the end of January 2018 without registering with us. However, the provider had recruited a new manager who had not commenced in post at the time of our inspection. The provider was aware of their legal requirement to have a registered manager in post and was hopeful the new manager would submit an application to us. We will be following this through with the provider to make sure they meet their legal obligations.

The provider told us, in order to sustain improvements they had recruited a new manager and the provider would be recommencing their own quality checks. However, this was the fifth consecutive inspection where the provider had an overall rating of requires improvement. This meant we do not have the confidence the provider would be proactive in identifying improvements as opposed to being reactive when we identified concerns.

The provider had not ensured that required improvements were made and sustained in order to achieve a good rating following the last inspection. The provider told us they were aware their quality checks had lapsed and it was difficult to find all the previous one's which had been undertaken by the former manager so monitoring could be consistently tracked over a period of time. However, the provider told us they were committed to making improvements so they had an effective oversight of the management of the home. This provider also wanted to improve their quality checking arrangements and in reference to what we found they said, "It would not be repeated."

The provider's quality checking arrangements had not been consistently robust and effective in identifying areas which required improving and sustaining these during the changes in management at the home. Whilst the former manager undertook quality checks, these had not been consistently completed following their departure in January 2018. Because of the changes in management and the lapse in the provider's own oversight they could not assure themselves of the quality and safety of people in their care. The provider told us their oversight of checks undertaken had lapsed in October 2017.

Over the two days of this inspection we found examples whereby the lack of the provider's oversight and quality checks had impacted on them not identifying where there were breaches in regulations. For example, we identified risks to people's safety and welfare were not consistently mitigated. In addition, the information about people's needs and risks were not always written into care plans so staff had guidance to support people to receive consistent safe and effective care.

There was a lack of management oversight of people's medicines to enable the provider to assure themselves staff practices were consistently effective and learning opportunities could be identified in a timely way. For example the provider had not made sure following the former manager's departure, the systems to quality check medicine administration and management over a period of time, were undertaken. Following our inspection the provider told us the new manager was implementing paper based medicine administration records, 'To enable easier completion and inspection with the new nurse group.'

The provider had arrangements in place whereby senior staff had responsibilities to check and monitor aspects of people's care. However, senior staff's practices had not been checked to ensure they had fulfilled their responsibilities. We found examples whereby the monitoring of people's weight loss had not been followed through to reduce the risks associated with malnutrition.

In addition, the provider's monitoring procedures had not assisted them in identifying when incidents of abuse had taken place. The lack of tracking and analysing of incidents and accidents did not support the provider to assure themselves risks to people in their care had been consistently reduced.

The provider had plans for the home environment to redecorate and provide new furniture where required. However, we saw examples in the facilities for people where repairs had not been reported and the provider's systems had fallen short in driving through improvement actions in a timely way. The shortfalls in these practices impacted on people having a pleasant place to live where the facilities supported their safety, independence and dignity. Examples included, a faulty tap, torn shower curtain, clinical waste stored in a bathroom, unpleasant odour from a carpet in a lounge area and a notice which did not have the right information about the room on the door.

Furthermore there were inconsistencies in the provider's own oversight measures to reduce the impact of risks to people in relation to faulty appliances. There was a book which had a note to confirm it was used for staff to communicate issues to the provider where action was required. These issues included a staff member noting there was a smell of gas from the cooker and another issue which informed the provider a small portable electric heater had overheated. The provider was unaware of these issues which had not been addressed to ensure people's safety until we discussed them with the provider during this inspection.

All the above shows the provider's oversight and quality systems had not been operated effectively to ensure people received consistently safe and good quality care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's ineffective quality checking systems and oversight of the service had been ineffective in identifying when an incident of abuse had occurred. This meant the provider had failed to notify us of an incident of abuse as required under our registration regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Despite the above concerns, people living at the home, visitors and relatives were positive about the friendly atmosphere in the home and the caring nature of the staff group. One person told us, "I like it here and they [staff] are all friendly to me." Another person said, "It is a friendly place." One person's friend told us, "I would not think of changing or moving her from here. I feel rested and contented when I leave from here that she is in good hands. I visit every day." A health professional commented, staff were responsive to a person's health needs so they remained healthy and well.

Staff told us they felt supported in their role by each other and they worked as a team in order to meet people's needs. One staff member said, "We are a close knit family, we all get along. Management are

approachable." Another staff member told us, "Management okay, were happy and residents [people who lived at the home] are." Staff told us they were confident about raising concerns about any poor practices witnessed and felt able to raise concerns and issues with senior staff. Meetings with staff had been held and staff told us they were able to make suggestions, such as cutlery needing to be replaced. This suggestion was taken on board and new cutlery provided.

The provider was taking some steps to improve the home environment for people. For example, they had redecorated and provided new furniture in some areas of the home. However, there were further improvements needed, such as redecoration in other parts of the home. The provider was aware improvements needed to continue and provided us with an action plan to reflect the improvement work which was being undertaken. The provider pledged to progress the refurbishment work, so the home environment was of an acceptable standard so people in their care had a pleasant place to live. We will look at how the provider has progressed with this work at our next inspection.

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 provider had failed to notify us of an incident of alleged abuse as required under our registration Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to the health and safety of people had been fully assessed and with action taken to mitigate some risks.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure people were consistently provided with a good quality service.

The enforcement action we took:

We took action to impose a condition on the provider's registration. This condition requires the provider to update us monthly by sending reports to show how they are addressing the breach in Regulation 17.