Swallowcourt Limited

Poldhu

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 26 July 2017 and was unannounced.

Poldhu is a care home that provides nursing care for up to a maximum of 63 older people. At the time of the inspection there were 50 people living at the service. Some of these people were living with dementia. The accommodation is arranged over three floors.

There was not a registered manager in post at the time of 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. There had been some changes to the management of the service. There were two new managers in post, one of whom was also the clinical lead. The clinical lead told us they would be seeking to become the registered manager.

At the comprehensive inspection on 20 February 2017 we found a number of concerns. The inspection had taken place, in part due to an incident in which a person had fallen in their bedroom. The person had used their call bell to alert staff, however it had taken them over 40 minutes to respond. This put the person at risk of harm. We had concerns about the length of time it took staff to answer call bells. At this inspection, we continued to have concerns about this. The service had set itself a target of responding to call bells within 20 minutes. Although they were mostly meeting this target by day, there were very frequent incidents where people waited longer than this to be assisted by staff during the night. We saw an example where this had happened 25 times in one night. The longest time we saw that somebody had waited for staff to answer their call bell at night was over 55 minutes.

The service used a dependency tool to calculate how many staff were needed to be on duty to support people well. We saw that the staff on duty matched the levels indicated by the dependency tool. Some staff reported that staffing levels were low and this meant people were sometimes responded to less promptly. One person and a relative also said they thought there were not enough staff.

At the inspection in February 2017, we had concerns around how the service responded to complaints. Complaints were not always recorded or action taken to minimise the possibility of incidents reoccurring. At this inspection, we saw that improvements had been made to how complaints were investigated and that any lessons learned were shared to reduce the likelihood of the issue happening again wherever possible.

At the inspection in February 2017, we had concerns that care plans did not always give a comprehensive overview of people's needs. We continued to have concerns about this during this inspection. Information in care plans was not always accurate. In addition, care plans did not contain enough guidance for staff on how to provide people with personalised care. We saw that care plans were based on risk assessments which were out of date and therefore no longer an accurate reflection of the person's needs.

At the inspection in February 2017, we found that auditing systems were not fully established. There were gaps in medicines audits. Infection control audits were not taking place. At this inspection, we found that audits were being undertaken regularly, however there were not always action plans to address issues identified. There had been no follow up to medicines errors which were highlighted on the medication audit. In addition, audits had not identified other areas of concern which we found at the inspection.

People's rights were not always protected because the principles of the Mental Capacity Act (MCA) were not always followed. We saw examples where relatives had signed to consent on a person's behalf without the correct legal authority to do so. A person was subject to restrictions which were not proportionate or authorised by a lawful process.

We had concerns relating to the safety of the environment. For example, a number of shared bathrooms contained items which were potentially harmful, such as disinfectant. The water from the tap in one person's bedroom was extremely hot and posed a potential scald risk

The environment was bright and spacious with spectacular sea views and lots of areas to relax. However the service was not dementia friendly. There was a lack of signage or methods for people to orientate themselves.

Medicines were generally safely managed, however we saw that errors recorded on audits were not followed up, meaning that learning from them might be missed. We also saw that one person's records suggested they could have their medicines covertly. However, there was no covert medicine agreement from this person's doctor in place, to support this being done.

People's health care needs were not always effectively monitored. People had monitoring forms in their rooms, which were stored in disorganised files. We saw that these were inconsistently completed by staff and there was no recorded monitoring of these records. This meant the records were not effective or an accurate picture of the person's treatment.

Staff were kind and caring. We observed warm, positive interactions between people and staff. Staff spoke to people with respect and promoted their dignity and independence. People told us they were happy living at the service. People's records evidenced that they had access to advocacy services. People's confidential information was securely stored.

People were supported by staff who had undergone training to carry out their role. Staff were supported by an induction and an on-going programme of supervision and appraisal. There were regular team meetings in order for staff members to meet as a group, support one another and share any ideas or concerns.

People were supported by staff who had been safely recruited. Checks had been undertaken to ensure they were suitable to work with people who were vulnerable.

At this inspection we identified breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe.

Call bells were regularly not answered promptly putting people at risk of harm.

People's health needs were not always safely monitored.

Actions intended to restrict people, were not always proportionate.

People's safety was not always protected due to a number of hazards within the environment.

People's medicines were generally managed safely.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

People's rights were not always protected as the principles of the mental Capacity Act (MCA) were not followed correctly and restrictions were not always lawfully authorised.

People's consent was not always sought appropriately.

People were not always protected by a dementia friendly environment.

People were supported by staff who had undergone training to carry out their role effectively.

Is the service caring?

Good

The service was caring.

People were supported by staff who were warm, kind and compassionate.

People told us they were happy living at Poldhu.

People had access to advocacy services when required.

People's confidential information was securely stored.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always accurate or up to date and did not contain sufficient guidance for staff.

There was a system in place for receiving and monitoring complaints.

People had access to a wide range of personalised activities.

Is the service well-led?

Requires Improvement

Aspects of the service were not always well led.

Quality assurance systems were not always effective in identifying areas of concern found at this inspection.

Issues identified on audits did not evidence what follow up action had been taken, or whether lessons had been learned.

There was a new management team in place who were committed to making changes and to improving the service.

Poldhu

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 26 July 2017 and was unannounced.

The inspection was carried out by two adult social care inspectors, a specialist advisor with a nursing background and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before visiting the service we reviewed information we kept about the service such as previous inspection reports and notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern. Before the inspection, the provider completed a Provider Information Return (PIR). 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.

During the inspection we spoke with 14 people who used the service and observed others who were less able to communicate verbally. We spoke with three relatives and obtained their feedback. We spoke with the manager and the nominated individual and 11 members of staff. After the inspection we contacted three external health and social care professionals who visited the service regularly in order to obtain their feedback. We inspected the premises and observed care practices during our visit. This included the lunchtime experience. We looked at ten records which related to people's individual care. We also looked at three staff files, a range of audits, policies and procedures and other records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in February 2017 we found concerns in relation to call bell answering times. There had been an incident where a person had fallen and staff had not answered their call bell for over 40 minutes, placing them at risk. Following the inspection, we received an action plan from the provider, detailing how the issues identified would be addressed.

At this inspection, we continued to have concerns about call bell answering times. We reviewed the call bell log kept by the service, as well as audits of call bell answering times. The service had set itself a target of answering bells within 20 minutes at the maximum. We found very frequent occurrences where this was not the case, particularly at night. We saw that on one occasion, staff had taken longer than 20 minutes to answer a call bell, 25 times in one night. The longest staff had taken to respond was over 55 minutes. We spoke with the managers about this. They agreed that it was not satisfactory and were looking into methods to address it, such as changes to staffing patterns and allocating staff to designated rooms at the service. Staff meetings had been scheduled to look at the issue and to consider ways of improving it.

Prior to the inspection, we heard concerns that one person had become dehydrated at the service and that this had not been promptly identified by staff. At this inspection, we found people's health care needs were not always safely monitored. People had folders in their bedrooms containing daily monitoring forms, for example, to document their fluid intake and pressure care. We saw gaps in these recordings and also that daily balances were not kept. This meant that it was not possible to have a clear understanding of the care and treatment people were receiving and whether it was safely meeting their needs from reading the records. We also saw examples where people were not using the correct equipment for their needs. One person was sitting on the wrong type of cushion to prevent skin breakdown. Minutes of a recent staff meeting indicated that some staff members did not know the correct cushions to use for people. It was not clear what action had been taken to address this.

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

Staff had received training in safeguarding adults and we saw information around the service informing them on how to make an alert if required. However, we found that people were not always safeguarded from abuse and improper treatment. Some restrictive practices and controls had been imposed without a lawful process to ensure they were a proportionate and necessary response to the risk of harm posed by the person. For example, one person's records stated that when their relative visited, they must remain in line of sight of staff and not be alone in the person's room. There was no evidence of any process having taken place to ensure that this was necessary and proportionate or that there was any legal authority to impose this control. This meant there was a risk this person's privacy might be infringed. One person's care records stated that staff had; "retrieved their phone" after they had first refused to give the phone to staff. This also meant the person's right to privacy was not being respected.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found some concerns relating to the safety of the environment. For example, a number of shared bathrooms contained items which were potentially harmful, such as disinfectant. A mop and bucket with dirty water and disinfectant was unattended in one corridor. There were also unmarked toiletries in shared bathrooms, exposing people to a risk of cross infection. We saw some trip hazards in corridors such as leads and cables, as well as an unattended medicines trolley. The trolley itself was locked, however there was a plastic container attached to it, which contained used medicines pots and packaging. We also noted a tablet in one of these containers.

The water from a tap in one person's bedroom was extremely hot and posed a potential scald risk. We advised the manager of these issues as we found them. They removed the potentially harmful and hazardous items and told us they were ensure the hot water from the tap was immediately addressed.

The nominated individual and managers were looking at ways to improve staffing arrangements. The service used a dependency tool to calculate what the staffing levels should be. We saw that the staffing levels matched those indicated by the dependency tool. This dependency tool was based on people's initial assessment upon admission to the service and the nominated individual explained that this required a review. The nominated individual explained that a full re-assessment of every person was going to be undertaken to ensure that care plans reflected people's needs and this could then make the use of the dependency tool more effective and accurate. Managers were also looking at the deployment of staff on shifts. The nominated individual explained, "A shift that may be running with less people, but the right people may be better". Whilst we observed suitable levels of care staff on the day of our inspection, we saw that nursing staff appeared very busy. The medicines round took four hours to complete. This may have created issues for people who required their medicines to be administered at regularly spaced intervals, as the afternoon medicines round was commenced shortly after the morning round. One person said; "I sometimes feel there are not enough staff on duty" and one relative commented; "I sometimes feel there's not enough staff on to make it feel completely safe."

People's medicines were stored and disposed of using the correct procedures. Medicines administration records (MAR) were accurately completed. Where medicines required refrigeration, fridge temperatures were logged daily and fell within the guidelines that ensured the quality of the medicines was maintained. Staff were knowledgeable with regards to people's individual needs related to medicines. However, we noted a number of medicines errors had occurred. These had been identified by the medicines audits; however, there was no action plan or follow up, to ensure that lessons could be learned from errors.

The service was visibly clean and free from adverse odours. However, we noted a lack of antibacterial hand gel in shared areas, such as lounges, corridors and the reception area. This could have meant opportunities to prevent the risk of cross infection were missed. We reported this to the manager and nominated individual who said it would be addressed. Staff had received training in infection control.

The environment was well maintained. There was a maintenance log available for staff to record any concerns. Records showed that manual handling equipment, such as hoists had been serviced. There was a system of health and safety risk assessment. Fire alarms and emergency lighting were checked by staff to ensure they worked. People had Personal Emergency Evacuation Plans (PEEPs) in place. These outlined the support people would need to leave the building in an emergency.

People told us they felt safe living at the service. Comments included; "I feel safe because the staff are ready to do anything for you,."; "They always make sure I have my call bell on hand" and "Staff are always popping in to see how I am". One relative we spoke with commented; "My mum has settled in well, so that makes her feel safe."

Accidents and incidents which had occurred at the service were recorded in detail. These were reviewed by the manager to look for any patterns or themes. This helped to reduce the likelihood of a re-occurrence.

People were protected by safe and thorough recruitment practices. Records confirmed all employees underwent the necessary checks prior to commencing employment to confirm they were suitable to work with vulnerable people. This included DBS (disclosure barring service) checks.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. We found that many capacity assessments were out of date, irrelevant or not decision specific. The principles of the Mental Capacity Act were not followed. One person's records indicated their medicines could be given covertly. There was no capacity assessment around this, or a best interest process. This was in contravention to the service's policy on covert medicines which stipulated; "Ensure any decision to undertake covert medication has been made through a best interest meeting, inviting all relevant parties and ensure the minutes are taken at the meeting and the minutes are placed on the resident's file".

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. 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. Where appropriate Deprivation of Liberty Safeguard (DoLs) applications had been submitted to the local authority. However, we saw that not all of the restrictions in people's care plans had been listed on the application, meaning some practices were not lawfully authorised. We reported these concerns to the manager and nominated individual.

People's consent was not appropriately recorded. We saw examples where family members, who did not have the correct legal authority, had consented to elements of the person's care or treatment. For example, consenting on their behalf to have photographs taken. Nobody can consent to an adult's care or treatment without the correct legal authority, such as a lasting power of attorney (LPA). If there is no LPA, a documented best interest decision must be made in line with the principles of the MCA. We saw that not all staff routinely asked the consent of people before assisting them with care. For example, some staff placed aprons over people's head at the dining table without asking them first, or explaining what they were doing.

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

We reported these concerns to the manager and nominated individual. They were aware of the issues and were in the process of working through care plans to update them and re-write them where necessary. They told us they would speak to staff about ensuring they gain consent.

The environment at Poldhu was bright and spacious, with several areas for people to either socialise or relax. There were spectacular sea views from the dining room and many of the bedrooms. Bedrooms were situated on the first and second floors and there was a working lift in place. Corridors and doors were wide enough to allow for wheelchair users to move freely around the premises. However, we noted that the environment was not dementia friendly. There was a lack of signage around the home for people to

orientate themselves. People's bedroom doors were not personalised to enable people to find them easily. All of the corridors were decorated in the same neutral colours, making it difficult to distinguish one area from another. The manager was aware of this issue and agreed that it needed to be addressed. There were plans in place to make changes to the environment to make it more suitable for those living with dementia, such as introducing different colour schemes in different areas of the home to make them more recognisable.

We observed that lunchtime was a pleasant and relaxed experience. Some people required support and encouragement to eat. We observed people being assisted by care staff and noted this was done at a pace that suited people. A member of the activity team played the grand piano during the meal, which created a pleasant, sociable atmosphere. Tables were decorated with table cloths and flowers and people were able to admire the sea views whilst they ate. People told us they enjoyed the food. Comments included; "The food here is excellent"; "We are blessed with a good chef" ;"The food is very good and very good quality"; "I eat in my room, and when it comes it is always nice and hot"; "The food is fabulous" and "The food is top class, couldn't be better". Special dietary needs such as diabetes were catered for. Some people required a pureed diet and there were arrangements in place for this. Where specialist advice had been given, for example, from speech and language therapists (SALT), kitchen staff were aware of this. There were a variety of options to choose from at mealtimes and people's feedback was sought on the menu. The cook told us that one evening they had prepared 17 different suppers at people's requests.

People were supported by staff who had received an induction. One staff member commented; "The induction is fantastic. It's all done in house". New staff shadowed more experienced staff to help them gain confidence in their role. One staff member told us; "New staff can shadow for as long as they like". Staff who were new to care undertook the Care Certificate. The Care Certificate is a nationally recognised set of standards for care staff. After completing the care certificate, there were knowledge tests to help ensure the staff member was competent in their role. All staff were supported with an ongoing programme of supervision and an appraisal.

People were supported by staff who had received training in order to carry out their role effectively. Staff had received training in areas identified by the provider as mandatory, such as safeguarding, moving and handling, fire safety and infection control and there was a system in place to remind them when it was due to be renewed or refreshed. Staff had also received training which was specific to the needs of the people they supported. One staff member told us that bespoke training packages were set up for staff if they had specific learning needs or interests.

We saw from people's care records that they had access to a range of health care professionals including GPs, speech and language therapists (SALT), district nurses, and chiropodists. Throughout the inspection, health and social care professionals attended to review people. One relative confirmed; "The home arranges physiotherapy appointments for my wife".

Good

Is the service caring?

Our findings

People told us the service was caring. Comments included; "The staff are very nice and caring,"; "The staff do everything for me, nothing is too much trouble"; "The staff are always around to help" and "The staff are marvellous". People were happy at Poldhu. One person commented; "I would really recommend this place to anyone".

We observed positive interactions between people and staff. One staff member was helping a person back to their bedroom after breakfast. The staff member greeted the person with a hug and the person was heard to say; "I am ever so fond of you. You and I have a real affinity don't we?" Another person pointed to a staff member and told us affectionately; "That girl is so kind to me".

Staff ensured that people who were new to the service were made to feel welcome. One staff member said; "Adjusting to coming into residential care can be hard for people. We support them in that transition, sit and listen to them and reassure them". The manager told us; "When someone new arrives we meet them with flowers and welcome packs. We want this to feel like home, not a place they have been sent to".

The atmosphere at Poldhu was very pleasant. We observed some people enjoying a late breakfast when we arrived. They were eating at a time of their choosing and leisurely enjoying the views from the dining room. We observed times during the day when people appeared relaxed, content and comfortable, enjoying calm and peaceful moments. We also observed people enjoying entertainment which had been arranged. A singer came to the service during the afternoon and this was very popular with both people and staff. During this time, there was an upbeat atmosphere with people singing, dancing and taking part, staff also joined in and appeared to be enjoying themselves

People's care records provided personalised information about their background, history, likes and dislikes. There was also information about their political views, whether they liked to vote and their religious and spiritual needs. This detailed information helped staff to understand the person and to provide care and support to them in the way they preferred. It also assisted staff in having meaningful conversations and forming positive working relationships with people.

Staff were committed to ensuring that care was delivered in a person centred way which protected people's individual needs and dignity. For example, care was taken to ensure people's personal clothing was returned to them. One person said; "The laundry service is excellent". People were asked daily if they wished to have a shower or bath. One person said; "I can have a bath at my choice of time and day".

People confirmed to us they were able to go to bed and rise at a time of their choosing. One person said; "I can get up and go to bed whenever I want, they leave it up to me". One person's care records stated; "Likes to get up when he wants. Sometimes likes an afternoon nap".

People's confidential information was securely stored in a locked office. Care plans were kept securely in an office.. We saw staff knocking on people's doors and waiting for a response before entering. Staff were

respectful and addressed people in the way in which they preferred. People's care needs were responded to by staff in a discreet manner. For example, when people required assistance with their personal care needs, staff assisted them without drawing attention to them.

We saw evidence that people had access to advocacy services as required. Contact details for advocacy services were also displayed around the service.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in February 2017 we found concerns relating to people's care records. For example, personal information was missing and monitoring forms were not meaningfully completed. Following the inspection, we received an action plan from the provider, detailing how the issues would be addressed. At this inspection, we continued to have concerns relating to the recording of people's care and treatment at Poldhu.

People's needs were not accurately documented and care plans lacked guidance for staff on how to manage identified risks. One person's records indicated they experienced paranoia and night time psychosis. Their care plan stated that staff should provide them with; "Support and reassurance". There was no further detail around what this meant for the person. Another person had been prescribed medicines to manage anxiety. Their care plan also advised staff to provide them with; "Support and reassurance". The lack of detail in these care plans meant that care might not be provided to people in a personalised way that was reflective of their needs.

Some risk assessments were out of date and no longer accurate. We saw an example where a risk assessment had been undertaken in 2016. The person's care plan had been written based on the risks identified in the assessment and had been regularly reviewed, most recently in May 2017 and signed as still being relevant. The risk assessment indicated that the person was a risk to others as they had bitten a staff member. The care plan indicated staff needed MAYBO training to manage his personal care interventions. MAYBO is a type of conflict resolution and physical intervention training. We noted that no staff had received this training. We asked the manager about this and was told the person was no longer a risk to staff and therefore staff did not need specialist training to assist the person with care. This meant the person may not receive care that was appropriate or a response from staff that was proportionate to the risks.

One person's records indicated they could have their medicines administered covertly. We looked at their records and found that there was no covert agreement in pace from this person's doctor. Although medication was not being given covertly to this person in practice, the inaccuracy of the records could have exposed the person to unsafe practices and risk. If staff had followed the care plan, covert medicines could have been given without the correct safeguards in place.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were plans in place to review and re-write people's care plans where necessary. The manager's agreed this was required and were already beginning the process.

At the inspection in February 2017, we found concerns relating to the management of complaints. There was no evidence that some complaints had been followed up or that actions had been taken to reduce the likelihood of a re-occurrence.

At this inspection, we found that improvements had been made. We saw examples were complaints had been followed up in a timely manner and where lessons learned were shared with those concerned. People and relatives we spoke with confirmed they knew how to make a complaint and felt satisfied any concerns would be investigated and dealt with appropriately.

People had access to a wide range of personalised activities. The service employed two activities coordinators who spoke with us enthusiastically about their role. There were daily scheduled activities as well as personalised one to one time. We saw photographs in people's care records of them in engaging in imaginative and personalised activities such as thai-chi, cheese tasting and a top hat and tiara party. Staff used an i-pad to look up pictures of classic cars with one person who had a particular interest in them. Boating magazines had been purchased for another person who had an interest in boats and there was scheduled one to one time for staff to look at these with the person. There were regular visitors to the service, including a variety of singers performing music from a range of genres including modern music, wartime music and sea shanties. There were also visits from petting animals. Comments from people included; "I really enjoy the singers that come in because I used to play in a band, so I can sing along"; "There's always something going on" and "We can do what we want, either join in or not".

Staff understood the importance of people maintaining relationships with those who mattered to them. During the inspection, we saw that relatives were treated respectfully and made to feel welcome and there were no restrictions on visiting times. We saw two relatives eating with their family member in the dining room at lunchtime. Comments from relatives included; "There are no visiting restrictions, I even stay and have a meal with my relative" and "The staff make me feel so welcome". People's pets were also welcome at the service. One relative said; "I bring our dog to the home so we can go for walks with [relative's name]".

There was information displayed around the service about specific health concerns which affected people living there. For example, there were fact sheets on staff notice boards about dementia and Parkinson's disease. This helped to ensure staff had an understanding of these conditions and what it might mean for the people they supported. There were also fact sheets in some people's care records. For example, one person's care record contained information about different types of seizures and how staff should respond if the person experienced a seizure.

Requires Improvement

Is the service well-led?

Our findings

There was a new management team at the service who had only been in post for a few weeks. This consisted of a general manager who was responsible for staffing and environmental issues and a head of care who would be responsible for nursing and care issues. The head of care told us they would be applying to become the registered manager. It was too early for us to make a judgement about the effectiveness of these leadership arrangements. However, both managers were enthusiastic about their role at Poldhu and had plans in place to improve the quality of the service. The provider had created a new position of clinical governance manager which had been filled by an experienced member of staff. The role of the clinical governance manager was developing and maintaining quality and auditing systems. The clinical governance manager oversaw a monthly Governance Forum, which was attended by all Managers and Deputies.
The new appointment was also responsible for checking care plans for new placements once the person had lived at the service for one month. Aside from the managers there were nurses, specialists (senior care staff, who had undergone additional training to support the nurses and undertake shift leader responsibilities) and care staff. There were clear lines of accountability in the service and arrangements for supervision. Most staff we spoke with told us they felt well supported.

At the inspection in February 2017, we found gaps in the auditing system meaning that there were not effective systems in place to monitor the quality of the service. At this inspection, we found there were some improvements to audits which were now taking place more frequently. However, the audits had not identified all of the issues and concerns we found during this inspection. In addition, there were not always clear action plans following audits to evidence what changes had been made, and how this had been communicated with staff. For example, the medicines audit highlighted medicines errors, but it was not clear whether there had been any changes or learning from these errors for the staff involved.

We found several environmental concerns, such as potentially hazardous items left in shared bathrooms, trip hazards and a tap in a person's bedroom which constituted a scalding risk. Although these issues were addressed, it was unclear as to why they had occurred to begin with. In addition, although the excessive call bell waiting times were being looked into, it was unclear as to why this was continuing to happen. The exact reason behind this failure was not fully understood by the managers. This meant systems in place to monitor the quality of the service and raise standards were not always effective.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff told us the managers were approachable. One staff member said; "The manager worked three night shifts with us recently. That was really nice. You can be isolated when you work nights so it was a good thing".

The service had an up to date whistleblowing policy, which supported staff to question practice. It clearly defined how staff raising concerns would be protected. Staff confirmed they felt able to raise concerns and

felt confident the management would act on them appropriately.

The manager and nominated individual promoted the ethos of honesty, learning from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The Duty of Candour is a legal obligation to act in an open and honest way in relation to care and treatment. The service had notified the CQC of significant events which had occurred in line with their legal obligations.

Regular staff meetings took place and were an opportunity to keep staff informed of any operational changes. They also gave an opportunity for staff to voice their opinions or concerns regarding any changes. As well as full staff meetings there were also meetings for each group of staff such as care staff or domestic staff. This meant meetings were relevant to the staff team.

A recent quality assurance survey had been sent to staff to gather their views on the service. Some of the findings of this survey indicated that staff morale was low. The managers recognised this and were using the feedback constructively to try to improve how staff were feeling through discussions with staff at team meetings.

There were plans for relatives and residents' meetings to be held at the service, although this had not yet started.

People told us the service was well led and that staff were committed to their role. Comments from people included; "We have hard working staff" and "All the staff seem to get on and work together."

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 11 HSCA RA Regulations 2014 Need for consent People's rights were not always protected as the principles of the mental Capacity Act (MCA) were not followed correctly and restrictions were not always lawfully authorised. People's consent was not always sought appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always safe because call bells were not answered properly. People's health needs were not always safely monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Actions intended to restrict people were not always proportionate or lawfully authorised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care records were not always an accurate reflection of their needs. Care plans did not always contain sufficient guidance for staff. Quality assurance systems were not always

effective in identifying areas of concern found at this inspection. Issues identified on audits did not evidence what follow up action had been taken, or whether lessons had been learned.