Croftwood Care (Cheshire) Limited

Elm House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

Elm House Residential Care Home provides accommodation for up to 40 people who require support with their personal care. The home is located in the town of Nantwich close to shops, public transport and other local amenities. The home is a two storey building and people live on both floors. The first floor can be accessed by a passenger lift for people with mobility issues. There are 38 single bedrooms and one bedroom which can act as double bedroom for people who wish to share. Car parking is available to the front of the building. On the days we inspected there were 39 people living in the home.

There was a registered manager in post at the time of our 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.'

During this inspection, we found breaches of Regulations 11, 12,13,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Some of the risks in relation to people's needs and care were assessed but not all of them and we found that some of the risk management guidance for staff to follow to keep people safe was limited. For instance, one person's bed rails placed them at serious risk of harm and one person's dietary records did not show they always got enough to eat and drink. We found therefore that the management of some people's risks did not show that the service was doing all that was reasonably practicable to protect them from harm.

Care staff spoken with had a good knowledge of safeguarding and the action to take should abuse be suspected but the manager had not always followed the required processes to protect people from the risk of abuse.

For example, unexplained bruising on people had not been recognised as potential abuse and reported appropriately to the local authority and the Care Quality Commission (CQC). There was also no evidence that any investigation into how and when the bruising had occurred had been undertaken by the manager so that any potential abuse could be identified. This meant that the systems and processes in place to identify and protect people from abuse had not been followed to ensure their safety.

We saw that people's care plans contained information about their day to day support preferences and wishes and people told us that these were respected by staff We found that the service was responsive to people's healthcare needs by organising support for people from a range of different health and social care professionals. For example, dieticians, district nurses, mental health teams etc but we found that they were not always responsive to picking up and addressing other aspects of people's care. For example unexplained bruising, unsafe equipment and a lack of coherent planning and action in respect of people's dementia care or emotional needs.

Some people who lived at the home had short term memory loss or dementia type conditions. We found that the legislation designed to protect people's ability to make their own decisions (the Mental Capacity Act 2005) had been followed correctly when a decision to deprive the person of their liberty was made. Other specific decisions in relation to people's care for example the decision to install bed rails had not always followed this process and we found that this aspect of service delivery required improvement.

During our visit, we found that at various times throughout the day there were insufficient staff to respond to people's call bells or calls for help. A staff presence in communal areas was also sporadic. Some of the people we spoke with told us that they did not think there were enough staff on duty at all times to meet their needs. One person expressed specific concerns about their safety at night as there were two staff on duty to care for 39 people. We spoke to the manager about this and found that there were no adequate systems in place to determine whether staffing levels were safe.

We saw that the majority of staff were recruited safely but found that one new member of staff had been promoted without a robust recruitment process or any formal evidence of their skills, competency and experience to fulfil the requirements of this more senior post. This meant the manager could not be assured that the staff member was capable of meeting the responsibilities of this more senior role in relation to people's care.

The provider had a range of audits in place to check the quality of the service. Some of the systems however were ineffective. Care plans audits did not identify the gaps or inconsistencies in people's information and had not picked up that some risks were not properly assessed or managed. Some of the actions identified from an external medication audit had not been acted upon properly and the manager's weekly medication audits had not picked this up and there were no systems in place to ensure insufficient staffing levels were identified and addressed. This meant the way the service was monitored and governed required improvement to be effective in mitigating risks to people's health, safety and welfare.

People views about the quality of the service were sought through resident's meetings. People's satisfaction with the food and drink on offer was also checked through mealtime audits. People told us that the manager and staff were open to feedback and always ready to listen. Accidents and incidents were recorded and monitored properly by the manager. This ensured people received the support they needed. The home's environmental and infection control audits were effective in ensuring that the home was clean, well maintained and safe.

The majority of people thought staff had the right skills and knowledge to care for them. Records showed that most staff had received adequate training and support to do their job effectively. Staff spoken with spoke about the people they cared for with genuine affection and demonstrated a sufficient knowledge of their needs and preferences. We observed staff to be warm, caring and patient and we observed them supporting people kindly and at their own pace.

The majority of people felt safe living at the home and said staff treated them well. One relative told us that although staff were kind and caring they were not always observant in the delivery of care.

At the end of our inspection, we discussed the concerns we identified during the inspection with the manager and found them to be open and receptive to our feedback.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risks in the planning and delivery of care had not always been fully assessed and appropriately managed.

Safeguarding procedures had not been followed to protect people from the risk of abuse.

Staffing levels were not always sufficient. Some people told us that sometimes staff were too busy to meet their needs in a timely manner.

The majority of staff were recruited safely but staff had not always been promoted to a more senior role in a robust way.

Medication was not always safely administered and managed.

Is the service effective?

Requires Improvement

The service was not always effective.

There were elements of good practice with regards to the Mental Capacity Act and Deprivation of Liberty Safeguards. Other aspects of people care which required legal consent had not always been gained by following this legislation.

Staff had received the training and support they needed to do their job effectively. People we spoke with felt the majority of staff were well trained.

People were given suitable choices at mealtimes and told us the food was good.

Is the service caring?

Good

The service was caring.

People and relatives said the staff were nice and treated them well.

Staff were observed to be kind and respectful. Staff supported

people at their own pace.

People's independence was promoted and people were able to make everyday choices in how they lived their lives.

Staff demonstrated that they knew people well and what they liked to be supported with in the delivery of care. Staff understood the importance of respecting people's wishes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received responsive support for their medical and physical health needs from staff and a range of health and social care professionals.
Other aspects of their needs and care for example unexplained bruising and emotional support were not adequately responded to.

People's social needs were being met by a range of activities and people told us they enjoyed the activities on offer.

The majority of people and the relatives we spoke with were happy with the service provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Some of the quality assurance systems in place did not effectively identify and address the risks to people's health, safety and welfare. This placed people at risk of harm.

People's satisfaction with the service was through resident meetings and people told us that the manager and staff were receptive to their feedback.

Elm House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 5 and 6 July 2017 and was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also contacted the Local Authority for their feedback on the service.

At this inspection we spoke with 12 people who lived at the home, five relatives, the manager, the home service manager and three care staff.

We examined a range of documentation including three care files, three staff files, training records, medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

We spoke with 12 people who lived at the home and five relatives. Most of the people told us they felt safe and were well looked after. People's comments included "I feel safe, I like it here". Another said "I feel safe. They're very nice, all beginning to know me". Most of the relatives we spoke with agreed with this. One relative said staff were "Very pleasant, very co-operative, ask them anything and they're keen to sort it out but they don't notice things, they don't pay attention".

The provider had a policy in place for identifying and reporting potential safeguarding incidents. We spoke with a care team leader about their understanding of abuse and the action to take in the event that any abuse was suspected. They demonstrated an adequate knowledge of safeguarding and the procedures to follow. We found however that the manager had not always followed safeguarding policies to protect people from potential abuse.

During our visit we looked at the care records belonging to three people who lived at the home. We found that incidents of potential abuse had not always been responded to appropriately by the manager in accordance with local authority procedures or the provider's own safeguarding policy. In addition, none of the incidents had been reported to the Care Quality Commission as a notifiable event in accordance with the provider's legal requirements.

For example, staff had recorded several incidents were two people were found to have unexplained bruising. Some of bruising was on more than one part of the person's body. There were no documented incidents of any falls, accidents or incidents prior to the bruising being identified and when we spoke with the manager about this, they were unable to provide a satisfactory explanation as to what had caused the bruising. Despite this, the manager had not ensured that an investigation into how and when the bruising had occurred had taken place. They had not referred the incidents to the local authority or the Care Quality Commission for further investigation and had not followed the provider's own policy in recording and responding to signs of abuse. During our discussion, we found that they lacked a clear understanding of their legal responsibility to follow these procedures in order to ensure people were protected from potential risk.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as appropriate action had not been taken to investigate and prevent abuse.

We saw that people's care files contained some evidence that the risks in relation to their health and welfare were assessed and regularly reviewed. For example, moving and handling, nutrition, pressure sores and people's risks of falls. We saw that where people had specific risks identified by these assessments, they were supported by both staff at the home and other healthcare professionals. We found however that not all of the risks in relation to people's care and safety were assessed and in some cases the risk management advice provided to staff to follow to mitigate these risks was insufficient or not adequately followed.

For example, one person had bed rails in place that had not been properly risk assessed. No assessment as

to whether the person actually needed the bed rails had been undertaken. We saw from the person's records that a number of bed rails incidents had occurred. Records showed that these incidents had caused bruising to the person and in some cases the person had come stuck in the bed rails. We saw that the cause of the incidents had been risk assessed but found that no appropriate assessment of the person's ability to keep themselves safe with bed rails in place had been undertaken. This meant no consideration had been given to whether the bed rails in place posed a greater risk of harm to the person, than not having them in place at all.

We checked the person's bed rail and saw that they posed a serious entrapment risk. This was because the gap between headboard and bed rail measured approximately 340mm (34 cm). Safe bed rail guidance issued by the Medicines and Healthcare Products Regulatory Body stipulates that this gap should be no greater than 60mm (6 cm). We spoke with the manager about this and showed them the gap between the headboard and bed rails. They acknowledged that they had not noticed the bed rails were unsafe. We asked the manager if any checks of people's bed rails were undertaken to ensure that they were safely installed and maintained. They told us that no checks were undertaken at present. This meant that there were no systems in place to check that people's bed rails were safe to use.

We asked the manager to ensure immediate action was taken to ensure this person's safety. On our return to the home the following day, the manager told us a new bed with integral bed rails had been purchased and was due to be delivered shortly.

One person's care records noted that they required a diabetic diet. Another person's care records stated they had swallowing difficulties which placed them at risk of choking. Risks in relation to these conditions had not been assessed and staff lacked clear guidance on how to provide safe and appropriate care to prevent them occurring.

We saw that the person who was at risk of choking required a special diet to maintain their safety. Both the speech and language therapy team and a professional medical team had been involved in this person's care but we found that information in the person's care file about their dietary needs was confusing and at times contradictory. This was because staff at the home had documented different advice from different professionals at various points in the person's care. No clear dietary plan had been put into place and staff lacked clear guidance on which professional advice was the most up to date. We spoke with the manager about this and they acknowledged it was confusing.

We saw food and drink charts had been put into place to record the person's dietary intake. We looked at the charts for June and the beginning of July 2017 and saw that they often went without anything to eat and drink from early evening until breakfast the following day. This meant that the person often went significant periods of time without access to appropriate nutrition or hydration. We asked the manager about this. They were unable to provide a satisfactory explanation.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

Some of the people we spoke with told us there was not always enough staff on duty to meet their needs. One person expressed concerns for their own safety at night. They said "There are two carers for 39 people and they are run off their feet and the call bells are going".

Three people also said that they were reluctant to use their call bells, especially first thing in the morning, as

staff were too busy to help. One person told us that they often had to wait a long time for their call bell to be answered but that they didn't used to have to wait. They said "We've had lots of new residents". Another told us "Staff don't really have the time to sit and chat".

The manager told us that from 8am to 10pm at night there was usually a care team leader on duty and up to four care staff. The manager was also available to support staff if needed during the day. This amount of care staff did not seem unreasonable based on the number of people who lived at the home. During our visit however, we found at times there were insufficient staff to respond to people's needs promptly or to identify when they needed support. There were several instances during our inspection when we had to seek staff support for people who had either pressed their call bell or were calling for help. We also found that at times staff did not respond to people's call bells with much urgency and people could be left waiting for support for several minutes.

The manager told us that after 10pm. the number of staff on duty reduced to two care staff. This meant that after 10pm at night, two staff members were responsible for the care and safety of the 39 people who lived at the home.

We discussed our concerns about the number of staff on duty with the manager. We asked them how they had ensured staffing levels were safe and sufficient to meet people's needs. They told us the number of staff on duty was the same as it had always been. We asked them if they undertook any formal analysis of people's dependency needs when determining how many staff should be on duty. They told us the provider did not have any system in place to do this. This meant there were no adequate systems in place to ensure that the number of staff on duty was sufficient to meet people's needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that there were sufficient staff on duty at all times to ensure people's needs were met

We looked at three staff files to ensure that staff members had been recruited safely. We saw that each staff member had an application form in place, evidence that they had been interviewed prior to appointment and had a criminal conviction check done to ensure they were suitable to work with vulnerable people. We found however that one staff member had been promoted to more senior roles without any robust evidence of their suitability and competency to do so or a proper recruitment process having been undertaken.

We looked at the arrangements in place for the safe storage of medication. We found that some medications were not stored securely. Prescribed creams were stored in people's bedroom with no evidence that it was safe to do so.

We saw that people's medication was mostly dispensed via monitored dosage blister packs. There were some 'as and when' required medications for example, painkillers that had been dispensed in individual boxes (boxed medication) for when people needed them.

We checked a sample of six people's medication administration records (MAR). We found that people's monitored dosage medication was administered accurately. There were some discrepancies however in the amount of boxed medication people had left in comparison to what had been recorded as administered. This meant a small number of medicines could not be accounted for. For example, there should have been 17 tablets left with regards to one person's medication according to their medication records. When we counted the medication the person had remaining, we found only ten tablets were left. This meant that seven tablets were missing and could not be accounted for.

We also found it was not possible to properly account for the administration of some these medications as staff had not always recorded the quantity of medicines brought forward from the previous month at the start of the new medication cycle. This meant it was impossible to tell how much medication should have been left in the medication trolley at any given time.

These incidences demonstrate the way in which some of the medication was stored, administered and recorded was not safe. This was a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations.

We looked at a sample of accident and incident records and saw that appropriate action was taken when people fell or had an accident. People's fall records were also reviewed monthly by the manager to ensure that people received the support they needed

We did a tour of the building and saw that it was well maintained, clean and free from odours. People we spoke with told us that they were happy with the standards of cleanliness and how the home was maintained. Regular environmental safety checks were carried out on the premises. The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected by external contractors who were competent to do so. There were also adequate systems in place to assess and mitigate the risk of Legionella infection in the home's water supply.

We noted however that communal bathrooms in the home did not have clinical waste bins in place to enable staff to safely dispose of clinical waste. During our tour of the building we found that personal and protective equipment used in the delivery of care had been discarded in ordinary bins. This was not good infection control. We spoke with the manager about this.

Some the people and relatives we spoke with also expressed concerns with regards to the laundry service within the home. One person said "Washing, you don't always get back what you send and new things disappear".

Requires Improvement

Is the service effective?

Our findings

Most of the people and relatives we spoke with were happy with the support they received from staff. One person said "They know what they are doing". A relative we spoke with told us "I feel very comfortable that they (the person) are being cared for".

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that 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. We found that improvements were required.

We viewed the care records of two people with dementia type conditions and/or complex needs. We found that there was evidence of the beginnings of good practice with regards to the Mental Capacity Act. For example, when applying to the Local Authority to deprive people of their liberty.

For instance, we saw that one person's capacity to keep themselves safe outside of the home had been appropriately assessed in accordance with the Mental Capacity Act 2005. A risk assessment of the person's ability to keep themselves safe had been undertaken and we saw that the decision made to restriction their liberty had been made as least restrictive as possible. We checked another person's deprivation of liberty safeguard and saw the decision to deprive the person of the liberty was also been made in accordance with the MCA. People also had access to an Independent Mental Capacity Advocate (IMCA) to support them to participate in decisions made about their liberty. IMCAs are a safeguard for people who lack capacity to make some important decisions. The IMCA role is to support and represent the person in the decision-making process and make sure that the Mental Capacity Act 2005 is being followed.

When we checked other decisions relating to people's care we found that the provider had not always complied with this legislation in order to gain legal consent. For example, we found that a decision to install bed rails on both people's beds had been made without seeking legal consent in accordance with the MCA. Bed rails are used to prevent people accidentally falling, slipping, sliding or rolling out of bed but they require formal consent for use, as they are considered a form or restraint. People's capacity to consent to this decision had not been assessed and there was no other formal evidence that they had consented to their use. We spoke with the manager about this, and they acknowledged that no capacity assessment had been undertaken.

This was a breach of Regulation 11 of the Health and Social Care Act. This was because the provider failed

to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

We looked at supervision and appraisal records in relation to three staff members and saw that they had received adequate supervision. Two of the staff whose files we looked at had been employed for less than 12 months which meant that an annual appraisal of their skills and abilities was not yet due. One staff member whose file we looked at had worked at the home for over a year and we saw that they had received an appropriate appraisal.

We saw that the majority of staff training was up to date. Staff training was provided in a range of health and social care topics such as safeguarding, dementia awareness, fire safety, food hygiene, mental capacity, moving and handling, infection control and hand hygiene. This meant that provider had ensured that staff received the training and support they needed to do their job effectively.

We saw that new staff employed at the home received an induction into their job role and a staff member we spoke with confirmed this. They told us that they had not been permitted to work directly with people who lived at the home until they had completed a three day programme of in-house training. This showed us that the provider ensured staff had a basic knowledge of how to provide safe care before they started to support people at the home. All of the people and relatives we spoke with felt staff had the skills they needed and felt confident they had the right training to do their job.

People told us the food at the home was good. Their comments included "I love the food here. They get you what you want if they can". Another said "They let me have fish every day because they know I like it".

We observed that a member of the catering team spoke to each resident mid-morning and asked them what they would like to eat. People were given a choice of two main courses to pick from and we saw that where people did not like what was on offer, they were offered an alternative of their choosing. For example, one person said they fancied cheese on toast and this was provided. We saw that fresh fruit was available in the dining room at all times and that people had access to a water machine. We saw that some people had snacks and drinks in their own room and one or two had their own refrigerators.

We saw that lunchtime was a busy and popular event. We saw that most people ate their meals in the communal dining room and chatted socially to each other. Staff served people's meals pleasantly and promptly and the atmosphere was warm and homely. Portion sizes were ample and people were offered a choice of hot or cold drinks.

We saw that two people's meals were placed on the seat of their rollator (walking aid) and that they were trying to eat their meals off this as opposed to a side table. We observed that they had to lean over the rollator at an uncomfortable angle as the seat on the rollator was too low. It did not look very dignified. We asked both people if they would prefer a side table to eat from. Both people said yes. We asked staff to provide them with a side table and this was facilitated immediately.

Good

Is the service caring?

Our findings

People were happy with the staff that supported them. People's comments included "They're all very nice to me"; "They are all very good" and "The ladies are very nice to me. We have a laugh and a joke". One person told us that whilst staff didn't have time to sit and chat with them, the home service manager was "Marvellous. They read all my letters to me. They are never too busy – very good".

People we spoke with told us that they were able to choose how they lived their life at the home. They told us that their preferences with regards to their care were always respected by staff and their independence promoted. For example, one person told us "They ask, do you want a wash or a bath. They ask what you want to wear, they do your hair and they get you what you want for breakfast". One person told us how they felt staff recognised and respected their wish to be as self-contained and self-reliant as possible and another said that staff recognised their wish and ability to manage their own medication. This showed us that people were given choice, control and independence to live their life as they wished.

A relative we spoke with that staff kept them up to date with any changes in the person's needs and care. They told us staff were "Very caring. If I ask a question about them (staff), straight away I get an answer. I think there is a good relationship between them and my mum".

During our visit, we observed positive interactions with staff at the home and the people they supported. Staff were observed to be kind, patient and compassionate. People were supported at their own pace and treated with respect.

For example, we saw one staff member assisting a person to get seated more comfortably and safely in their chair. They addressed the person by their name and explained what they were going to do to help them before support was provided. One person was seen enjoying a sing and dance with one member of staff and we heard them having a laugh and a joke with each other.

One person wanted to mobilise in an unsafe way. We observed this interaction closely. We saw that the staff talked to the person quietly, advised them of the risks of mobilising in this way, was kind and patient with the person at all times and gave them a range of ways that they could support them to mobilise safely. This approach was observed to work and the person was assisted in the way they preferred.

Staff we spoke with demonstrated a caring attitude towards people's care and spoke about the people they cared for with genuine affection. During our conversations we found that staff knew people well, knew what people liked to have help with and recognised the importance of supporting people's choices. For example, one staff member told us that it was important to respect people's wishes not to participate in activities and to support their wish to stay in their room or their favourite place to sit. People we spoke with felt listened to and four people specifically mentioned the staff members they were particularly close to. This demonstrated that people felt comfortable and well cared for by staff.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with felt that their care needs were met. People we spoke with said they had prompt access to medical and other healthcare support as and when needed. One person told us that their doctor made regular routine visits to them in support of their needs. Another said that staff had been "Brilliant" in providing support when they had a medical emergency.

The care records we looked at confirmed this. Records showed that people had access to a range of social and health care professionals in relation to their needs and care. For example, people had support from dieticians, speech and language therapists, occupational therapy, mental health teams and district nurses. This indicated that the service responded appropriately to people's medical and physical health related needs however during our visit we found that other aspects of people's care had not been picked up and acted upon appropriately.

For example, people's unexplained bruising had not been picked up and investigated by the manager, unsafe bed rails had not been identified and addressed and some aspects of people's care had not been properly care planned for example, the support people required with regards to their dementia or emotional needs. This meant staff lacked clear guidance on how to support people living with dementia or their emotional needs in a person centred way.

For instance, we saw that one person was screened for, and identified as living with 'severe depression'. Despite this, there was no care plan in place to advise staff on the symptoms of this person's depression, the support this person required with regards to this, or the signs to spot should the person's mental health decline further.

One person lived with dementia but we found that their care plans lacked clear information on how this condition impacted on their day to day life, their strengths and abilities to self- manage and the support they required from staff to enable them to remain as independent as possible, for as long as possible. This aspect of care planning and delivery required improvement.

The home employed an activities co-ordinator who provided a range of social activities each day. These activities were advertised on a noticeboard in the entrance area of the home. The activities on offer included; music and movement sessions, bingo, arts and craft, quizzes, a visit to a garden centre and a visit from a musical entertainer. On the second day of our inspection, we observed a session of bingo take place. We saw that it was a popular activity and that people were encouraged and assisted to participate in the session. People we spoke with told us that they enjoyed the activities provided.

People and the relatives we spoke with told us they felt any concerns they raised were listened to and responded to. One person said "If I complain, they listen. One person said they had asked staff to turn off the television in the communal lounge to be turned off at mealtimes and that staff had respected this. Another told us the manager was "Very good. He'll stand and listen to you. He says don't be afraid to ask if you need anything or you're in trouble".

We saw that resident meetings took place regularly where people's feedback on the running of the service and the care they received was discussed. We saw that where people had made suggestions for improvement or raised issues with the running of the home, the manager had responded to and acted upon these appropriately. The manager told us that no formal complaints about the service had been received since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

People and the relatives we spoke with thought the service was well managed and said the manager was approachable. One person told us "The manager pops in every morning to say hello, how are you".

We saw that the manager undertook a range of regular audits to monitor the quality and safety of the service provided. This included an audit of care plans, health and safety, accident and incident audits and medication audits. Some of the audits however were ineffective.

For instance, there were a number of inconsistences in people's care records about their needs and care that had not been picked up by the provider's care plan audits. For example, they had not identified that one person's dietary information was confusing or that capacity assessments in respect of people's bed rails had not been undertaken. They had not identified that one person's choking risks had not been risk assessed or that one person's mental health needs had not been properly care planned. This indicated that the provider's care plan audits were not always effective in ensuring the information about people's needs and risks was up to date and complete.

A weekly medication audit was undertaken by the manager and we saw that an audit by Boots pharmacy had been undertaken in May 2017. The Boots audit had identified a number of improvements to the way staff were recording and administering medication. Despite these checks however on the day of our inspection we found that the issues identified by Boots had not been addressed effectively. For instance, the audit had identified that carry forward amounts of medication had not been documented on medication records and that the exact time of administration of 'as and when; required' medication had not always been recorded. On the day of our inspection we found similar concerns. This did not demonstrate that medication audits undertaken by the manager were effective in identifying areas of concern or effective in ensuring that where concerns were identified they were properly addressed.

There were no adequate systems in place to ensure staffing levels were sufficient and during our visit we observed the number of staff on duty was not always sufficient to meet people's needs. During our visit, we observed that staff did not always respond to call bells in a timely manner and we found that the manager did not always investigate why. For example, we saw that one person's call bell was ringing for several minutes, yet the manager did not investigate why this was and one staff member simply walked passed the call bell monitor without responding to the call. This did not show active leadership.

We saw that senior staff employed by the provided also audited the service on a regular basis but that these audits and checks had also failed to identify the areas of concerns we found during our inspection.

These examples demonstrate that some of the systems in place to monitor and address quality and safety issues were ineffective as they failed to mitigate potential risks to people's health, safety and welfare. This meant that the management of the service required improvement. This was a breach of Regulation 17 of the Health and Social Care Act.

We saw that accidents and incident records were recorded and analysed to enable patterns in when or how people fell to be picked up and addressed. Mealtime audits took place to check that people were happy with the meals provided and regular infection control audits were undertaken to ensure the home was a clean and comfortable place for people to live in. We found that these audits were effective.

During our visit, we found the culture of the home to be open and inclusive. People were happy and comfortable in the company of staff and felt listened to and supported. Staff we spoke with told us the manager was very supportive and said they enjoyed working at the home. This demonstrated some aspects of good leadership.

At the end of our visit, we discussed some of our concerns with the manager and found them to be open and receptive to our feedback.

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 The provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

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 not ensured the risks to people's health, safety and welfare were appropriately assessed and managed. The provider had not ensure that medicines were stored and administered safely and recorded appropriately.

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 The provider had not followed safeguarding procedures or taken appropriate action to investigate and respond to potential abuse in order protect people from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Some of the systems in place to monitor and

address quality and safety issues were ineffective as they failed to mitigate potential risks to people's health, safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient staff on duty at all times to ensure people's needs were met