Care Quality Commission

Wells Care Limited

Wells Place Care Home

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

Overall summary

This inspection took place on 23 and 25 June 2015 and was unannounced. At our last inspection in August 2014 the provider met the regulations we inspected.

Wells Place Care Home is registered to provide accommodation and nursing care for up to 42 older people, some of whom are living with dementia. Accommodation is arranged over three floors, with access to the lower and upper floors via stairs or a passenger lift. 33 people were using the service at the time of our inspection.

There was a registered manager in post. 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.

Although people spoke positively about the care they received, this was not always reflected in their care records or reviewed in a timely manner. Care records did not always contain sufficient information to provide

Summary of findings

personalised care. Potential risks to people were identified, but full guidance on how to safely manage the risks was not always available. This left people at risk of not receiving the care and support they need. Care plans did not record all the information staff needed to care and support people in the way that suited them best and kept them safe.

People were supported by adequate numbers of staff who had been safely recruited. However, they were not supported by a suitably trained or supervised staff team which could lead to people's needs being unmet. There were insufficient arrangements to ensure that staff were appropriately trained and supervised to meet people's needs and carry out their role.

The provider had systems in place for checking and monitoring the quality of the service. However, these were not wholly effective in identifying areas for improvement and ensuring these were followed up. We also found that records related to staff and the management of the service were not readily available or consistently maintained.

People were protected from harm because staff understood their responsibility to safeguard people from abuse. Safeguarding matters were dealt with in an open, transparent and objective way and the service worked with the local authority to improve practice when required.

People told us they were treated well and staff were caring. Relatives similarly spoke positively about the care and support individuals received and felt able to discuss any concerns with the registered manager and staff. Arrangements were in place for people and relatives to share their views or raise complaints. The provider listened and acted upon their feedback.

People were treated with kindness and patience. Staff respected people's privacy and made sure individuals' dignity was protected. There were positive interactions and people were complimentary about the staff. Relatives told us people were well cared for and gave us examples of their family members' health and independence improving at the service.

People were supported to maintain good health and had access to healthcare services where required. A GP visited the home regularly and staff made appropriate referrals to other health professionals when needed. This included the involvement of dieticians and tissue viability nurses to support people's health and wellbeing. People were encouraged and supported to eat a nutritional diet that also recognised their choices. Staff took appropriate action when individuals were at risk of poor nutrition or dehydration.

People were able to take part in activities of their choice and were supported to maintain relationships with family and friends who were important to them. Although there was a varied range of activities provided we have made a recommendation about improving activities for people living with dementia.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to managing risk and care planning for people using the service, the support and training provided to staff, the systems for monitoring the quality of service provision and record keeping. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Risks to people's safety and welfare had not always been identified and managed. Needs were assessed, but plans of care had not been regularly reviewed to reduce the risks associated with people's care.

People told us that they felt safe and well looked after. Staff knew about their responsibility to protect people from harm and abuse. They were aware of any risks and what they needed to do to make sure people were safe.

There were enough staff to meet people's needs and staff were recruited safely because the appropriate checks were undertaken.

Appropriate arrangements were in place for the recording, safe keeping and safe administration of people's medicines. The provider was taking action to improve practice around medicines management following a recent pharmacy audit.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People were supported by staff that had not received appropriate levels of training and support to carry out their role and provide effective care.

Staff understood the importance of gaining consent to care and giving people choice. The provider acted in accordance with the Mental Capacity Act 2005 Code of Practice to help protect people's rights. However, where people need help to make decisions, their individual circumstances had not been reviewed in a timely manner.

Meals were freshly cooked and people had a choice about what they wanted to eat and drink. People were protected from the risks of poor nutrition and dehydration.

People received the support they needed to maintain good health and wellbeing. The service worked closely with health and social care professionals to identify and meet people's needs.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were caring and we observed kind and sensitive interactions between staff and people in the service.

Privacy and dignity was respected and people were supported to maintain relationships with those that were important to them.

Summary of findings

People were able to make choices about their end of life care and relatives were also involved in this process.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always accurate or up to date to clearly guide staff in the safe delivery of people's care. Care records did not always take into account their individual interests and preferences. These shortfalls put people at risk of inappropriate care.

Arrangements were in place for dealing with complaints and responding to people's comments and feedback. People and their relatives told us staff listened to any concerns they raised.

People were provided with a choice of meaningful activities to help promote their health and mental wellbeing.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

There were systems for auditing and monitoring the service but these were inconsistently applied and had not effectively identified the shortfalls or improvements needed.

People's care and monitoring records were not consistently maintained to accurately reflect the care and support provided to people. Other records for staff and the running of the service were similarly not well managed.

There was a registered manager in post and people using the service and relatives spoke positively about them.

Wells Place 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.

Prior to our visit we reviewed the information we held about the service. This included any safeguarding alerts and outcomes, complaints, information from the local authority and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law. We also reviewed previous inspection reports.

This inspection took place on 23 and 25 June 2015. The first visit was unannounced and the inspection was carried out by two inspectors. We spoke with eight people who used the service and six visiting relatives. Due to their needs, some people living at Wells Place were unable to share their views. 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 talk with us.

The registered manager was on annual leave at the time of our inspection. We spoke with the operations manager, the registered provider, four nurses, eight care staff, activities coordinator, the chef and quality assurance manager from one of the provider's other services. We observed care and support in communal areas, spoke with people in private and looked at the care records for seven people.

We checked four staff files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including health and safety records. We reviewed how the provider managed complaints and checked the quality of their service. We also checked how medicines were managed and the records relating to this.

Following our inspection the registered manager sent us some information about staff training, complaints and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

Not all risks to people's safety had been identified or addressed. People's Waterlow risk assessments were not descriptive of the care which was needed or provided. A Waterlow risk assessment tool is used to identify and categorise those at risk of developing a pressure ulcer. We looked at three care plans for people where this applied and saw preventative care planning was in place for those identified as being at risk. This included use of appropriate pressure relieving equipment, application of prescribed creams, turning charts and prompting with food and drink. However, care records did not always clearly record pressure ulcer management or when healing was complete. There was no clear system for linking Waterlow identified risks with other relevant risk areas, such as the malnutrition universal screening tool (MUST), mobility and incontinence.. The Waterlow score is dependent on an accurate calculation of body mass index which requires weight and height records. In one care file the Waterlow score had been assessed without details of weight and height. We eventually found records of weight, but could not find a record of height. Although it transpired this did not skew the assessment as the person was recorded as being a high risk, records were inaccurate.

We saw one person was shown as having had a pressure ulcer that had subsequently healed. There was no date of when the ulcer had healed or treatment had ended. There was a lack of supporting documents, such as detailed records or photographs charting the assessment of pressure ulcers, progress of treatment, its effectiveness and completion. When asked about photographs for a specific injury we were told they had not been downloaded from the camera because the person who normally did so had not been able to do it. We did not find photographic records of pressure ulcers in the care records we examined. It was not possible to assess the accuracy of pressure ulcer assessment in or the effectiveness of treatment in the absence of detailed records and/or photographs. We looked at the file for a person who had a pressure ulcer. A pressure ulcer had been identified in January 2015 and appropriate measures were in place to relieve pressure. Another pressure ulcer was recorded in May 2015 on a body map. We could not identify from the records whether the person concerned had one or two pressure ulcers or one pressure ulcer that had been ongoing since the start of the year. There was no indication in records that the earlier pressure sore had healed or treatment was continuing. Staff were unable to tell us if there were records relating to pressure ulcer management stored elsewhere. In records of other people we found that body maps were often completed but it was not always clear what the entries related to. On one body map we could not correlate an injury shown with any other records. Other risk assessments we saw had not been reviewed since October 2014. There was a risk that staff may not take the correct action as they did not have the necessary information in the care plans to give them direction. This showed risk assessments were not always reflective of people's individual needs and we were not assured that staff were being supported to provide safe and appropriate care and treatment at all times.

We also found that where people were receiving medicines covertly in their food, this was not done in accordance with the Mental Capacity Act 2005. The provider's policy on covert medication stated, "Any resident who is having medication administered covertly must have a mental capacity assessment and a best interests assessment completed." The policy also required documentation of a pharmacist's confirmation that prescribed medicines could be mixed with food. The safety or effectiveness of some medicines could be compromised if mixed with food or liquids other than water. In one file of a person receiving covert medicines there were no records of mental capacity assessments or best interests meetings relating to their use. In the 'This is me' section of the care file it was recorded that medicines were crushed and taken in food. The records for medicines administration (MARs) noted the doctor had spoken to a family member. There was a care plan for covert medicines. The service had administered medicines to this person since August 2012. The last review had taken place in October 2014 but contained no details of what the review entailed or any reference to further mental capacity assessments or best interests meetings. There were no records of consultation with the pharmacist confirming the medicines could be crushed in food. The reviews did not identify whether there had been any changes in medicines or if they were unchanged. If there had been changes there were no records of consultation about their suitability to be crushed and administered in food.

These concerns were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

All medicines, including controlled drugs, were stored securely and administered by appropriately trained staff. Staff were supported with clear policy and procedures covering medicines management. The service had recently been audited by the pharmacy they used to obtain medicines and some minor areas of concern had been identified and were being addressed. We examined a random selection of medicines records and spoke with people and staff. The MARs were kept in three files at the nurse's station. One file provided by the pharmacist proved to be the most complete. It contained information sheets with the person's details, their preferred name, how and where they liked to have their medicines and included an up to date photograph. However, other information sheets we saw were handwritten and most had no photograph. The provider's policy stated that each person must have a laminated 'Medication Information Sheet' with the MARs. We observed one nurse administering medicines having to ask another member of staff to identify the person the medicines were for. The purpose of having up to date photographs with MARs was to reduce the risk of administering medicines to the wrong person. Members of senior management told us the medicines records were in the process of being reviewed and updated by a member of staff. We saw records to support this.

We also looked at references to medicines within care plans. Some people were taking specialised medicines and specific risk assessments and guidance were available to staff to ensure these medicines were administered correctly.

We examined a selection of MARs and found that they had been completed correctly and were up to date. There were systems and records in place for the supply & ordering, receipt, storage, dispensing and disposal of medicines. Medicines and controlled drugs were securely and appropriately stored. Relevant temperatures were monitored and recorded. We checked a random selection of medicines and records and were satisfied that there were sufficient medicines available for people and records were correctly maintained. A small box refrigerator had been supplied to store medicines requiring refrigeration and it was operating within the required temperature range. The refrigerator was free standing on the floor and the only way to examine the contents was to sit on the floor and pull items out. This was not conducive to regular use by staff. Members of senior management told us there were imminent plans to refurbish the room as a clinical room with appropriate storage and work surfaces for medicines management.

Discussions with staff showed an awareness of risks to people's safety arising from their individual care needs. They had a good understanding of potential hazards and the action to take to reduce the risk of people being harmed. For example, staff recognised the importance of correct moving and handling when supporting people. They told us they had received training in how to care safely for people who needed assistance with mobility. One staff member had completed a course to deliver this training which was repeated every six months. Staff were aware of other risks affecting people and the support that individuals needed, for example to reduce the risk of falls and poor nutrition. This included making sure food and fluid intake was closely monitored and ensuring that people had accessible call bells and sensor fall mats where needed.

People using the service said they felt safe living at Wells Place Care Home. Relatives expressed similar confidence about the safety of their family members. There were notices in the home with contact numbers that staff, people who used the service or visitors could use to report any concerns regarding abuse.

Staff knew who to report any concerns to, how to respond to any allegations of abuse or other serious incidents and what to expect as a result of reporting any such concerns. They knew the process to follow if they had any concerns about the safety of a person using the service. The local authority told us they had been working with the home following five recent safeguarding referrals and two monitoring visits. CQC records showed that these safeguarding matters had been reported appropriately and the provider had cooperated with the local authority and other professionals to investigate events. We saw evidence that the staff had worked with other professionals to look at how they could improve the care for people; this included a refresher moving and handling course for all staff and training on pressure ulcer management. The local authority were also due to provide safeguarding training for staff in the coming months. At the time of our inspection two of the five safeguarding investigations were still in process.

Requires Improvement

Is the service safe?

People were kept safe in a suitably maintained environment. We looked around the home including all bedrooms, communal toilets and bathrooms and spent some time in all communal areas of the home. Overall, we found the environment was well maintained and decorated to comfortable standards. The provider employed maintenance staff that carried out any work required. The laundry room was being renovated at the time of our inspection.

There was appropriate documentation for servicing and routine maintenance in the premises. The records were up to date and evidenced that equipment was regularly checked and safe for people to use. This included maintenance checks on wheelchair safety, the lift, hoists and adapted baths. Fire alarms and equipment were tested to ensure they were in working order. There was an emergency evacuation plan that identified the help individuals would need to safely leave the building in the event of a fire. This was out of date, however, following our inspection the manager sent us a revised document. Fire evacuation drills were held regularly involving both people using the service and staff. Newer members of staff confirmed that they took part in a fire drill as part of their induction.

People said there were enough staff around when they needed assistance. For example, we saw that there was always a staff member in attendance in the lounges and that people received adequate support to eat their meals. Relatives did not express any concerns about staffing levels. One visiting relative told us, “By and large staffing has much improved.” Staff felt there was enough of them to give people the support they required.

On the first day of our inspection, two agency nurses were working in the home and told us a senior carer was in charge. When the operations manager arrived they explained that two regular nurses were on a training course and they were covering the home in the absence of the manager. They added that the service had experienced staffing difficulties in recent months and additional recruitment was needed to fill vacancies. The provider was in the process of recruiting three nurses and care staff, including a deputy manager. To cover the vacancies and maintain consistency of care for people, we were told that regular agency staff worked in the home. There was a registered nurse on duty at all times to meet the needs of those people who needed nursing care. The staffing levels were supplemented with a separate cook and activities co-ordinator as well as ancillary domestic and laundry staff.

Staff we spoke with and records we saw showed the provider followed safe recruitment practices. Information held confirmed that the required pre-employment checks had been undertaken prior to staff working in the service. These included employment references and Disclosure and Barring Service (DBS) checks to ensure staff were of good character. Prospective employees completed an application form, provided forms of identity and had a formal interview as part of their recruitment. The provider had policies and procedures for when concerns were raised about the conduct or performance of staff. This helped to ensure that people were protected from unsafe care.

Requires Improvement

Is the service effective?

Our findings

Our discussions with staff showed they had knowledge and awareness about people's needs and how to support them. For example, individual staff members could describe relevant aspects of dementia care. One told us, "People will often talk about past memories, communication is important, to talk clearly and repeat things." Another staff member said, "listening is important, use small sentences/ easy words and provide pictures to help people choose food and activities." Staff told us they had recently refreshed their practical training in moving and handling in April 2015. Aside from this however, staff consistently told us they had not received regular training. One staff member told us there was "not enough" training and another told us they had done most of their training in their previous employment.

The majority of training was available as e-learning (computer training) through the provider. Other courses were arranged through external agencies including the local authority. An electronic training record enabled the provider to monitor the training staff received and ensure they were up to date. Following our visit, the provider sent us the most up to date list of completed staff training which highlighted a number of gaps. This was supported through discussions with staff. For example, only the registered manager had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. One staff member told us they had completed a range of training in their previous employment but had not undertaken any since they joined the service several months ago. A second staff member said they had asked for refresher training in a specialised area but this was yet to be arranged. Another staff told us they had not undertaken any training in dementia. Agency staff were working in the home, but there were no records to show that they had received an induction or had the competencies and skills to meet people's needs.

We were unable to find evidence in staff files that all staff had received formal supervision and annual appraisals. For example, of the four staff recruitment records we checked there were no records available of supervision and appraisal for these members of staff. An appraisal provides a framework to monitor performance, practice and to identify any areas for development and training to support staff to fulfil their roles and responsibilities. Discussions with staff supported what we found and they told us they had not had regular formal supervision or appraisal.

People did not receive care and support from staff that had the right knowledge, experience and skills to support people. Staff were not being provided with a formal support system to look at their individual practice and professional development. This meant there was a risk that poor practice or lack of knowledge would not always be addressed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated that they gained people's consent and involved people as fully as possible in day to day decisions. During our inspection staff always sought people's permission before carrying out any care or support. One staff member told us, "[name of person] sometimes refuses assistance from male staff; I respect [their] choice." Other staff were clear about respecting people's decisions to refuse and what action to take if they were concerned about the impact on a person's health or wellbeing.

We saw some evidence that people had been consulted about how they wanted their care and support to be provided. Records showed evidence of input from relatives, wherever possible, to ensure decisions were being made in people's best interests. One person had signed in agreement to the use of bed rails to keep them safe although there was no evidence of any further reviews taking place since July 2013. We saw mental capacity assessments had been completed when people lacked mental capacity to make decisions about their care and treatment. However, some of these were out of date. The operations manager told us that care records were in the process of being reviewed and updated.

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) and are in place to ensure people are looked after in a way which does not inappropriately restrict their freedom. The front door was locked and could only be opened by a keypad entry system. The operations manager told us that the registered manager had submitted DoLS applications to the local authority for relevant people so they were not unlawfully deprived of their liberty. The outcome of these applications was still in process at the time of our inspection. Staff told

Is the service effective?

us they had not received training on MCA or DoLS although they did show some understanding of the legislation. For example, they were aware that family and other professionals must be involved if a person lacked capacity to make a decision.

On the day of our inspection the weather was particularly warm. We saw that people were regularly offered drinks or were prompted to drink. We observed the lunchtime experience on both days. People were not rushed and staff encouraged people to eat and drink. One person told us, "The food was good, I enjoyed it." Another person said, "It was some kind of meat but it was very nice and the pudding was nice." People's individual's likes and dislikes were taken into account. This information was obtained as part of an assessment when a person first came to the live at the service. Relatives confirmed that they were consulted about their family members' food preferences and dietary needs.

The catering arrangements had recently changed and a new chef had been appointed. People told us this had been a positive development and the food had greatly improved. One relative said, "the food is very good, [name of family member] gets lots of it, the chef is excellent."

We spoke with the chef who had been working at the service for four weeks and had previous experience of catering in care homes. The chef had reviewed the kitchen facilities and requested improvements to the equipment. The provider told us that they had agreed to make a significant investment to improve the kitchen facilities. New kitchen and dining equipment was delivered during our second visit.

The chef told us they spoke to people every day to get feedback and to find out what people liked. They were aware of people's specific dietary requirements and tried to accommodate their nutritional needs with choice. We asked for a specific example and were told about a person who liked to have meals that reflected their nationality but did not meet their dietary needs. The chef spoke with the person, considered their dietary needs and came to an agreement with them. On two days a week the person could eat the food they liked and for the rest of the week eat healthily. As a result the person was eating more healthily which was reflected in their health observations.

The daily menu was displayed clearly in the dining room and on individual tables for people to see. The menus were varied, printed in large type and included pictures to promote choice. This was a six week rotating menu that was open to review. The provider had ordered a glass fronted refrigerator so that sandwiches, fruit, smoothies would be available to people outside of set mealtimes. They were also looking at providing tea and coffee making facilities for those people who were able to make hot drinks.

People had their weight monitored at least once a month or more often if required. Appropriate professionals had been involved where people had been identified as at risk of weight loss and malnutrition. Care plans had been put in place to ensure staff were aware of dietary needs such as food supplements and the risk of choking. We looked at nutrition in care records and found that people were assessed using the malnutrition universal screening tool. For example, one person was identified as having a poor appetite and the care plan directed staff to encourage the person to eat and drink, record fluids consumed and record the person's weight regularly. They were also provided with fortified drinks. Records reflected that staff monitored how much people ate and drank and discussions showed staff were aware of people's individual needs.

People felt their health needs were met, they told us staff took prompt action when they were unwell and said they saw the GP as and when required. Relatives we spoke with told us the home took prompt action if their family members needed medical treatment. A GP visited the service twice a week to attend to any health concerns and review medicines where required. Other multi-disciplinary services were available when required. People were supported to attend dental, chiropody, optician services and other medical appointments externally. We saw evidence of healthcare needs being identified in care records and that people had seen other specialists where appropriate. For example, a referral to the respiratory team and cardiologist was arranged for one person following a change in their needs. We saw clinical observations were recorded for those people requiring nursing care or those prescribed certain medicines. The manager and staff had begun to write hospital passports for people. This is a document which contains important information about a person's health and helps ensure all professionals are aware of a person's needs. For example, when attending health care appointments or if people required a hospital stay.

Requires Improvement

Is the service effective?

People had mobility aids and other specialist equipment to promote their independence such as walking frames, hoists and bathroom adaptations. Picture signs were on toilet and bathroom doors and names and photographs had been placed on the majority of bedroom doors. The operations manager advised that remaining signage was due to be arranged for people who had recently moved in. Bedrooms were furnished in a personalised way that helped people with memory loss to retain a sense of identity and comfort.

Good

Is the service caring?

Our findings

We spoke with people and visitors about their relationships with staff. People's comments were mostly positive and described staff as "kind", "caring" and "respectful". One person told us, "I suppose as homes go, this one is pretty good." Another person said, "I like it here, I am not going to complain." One person said, "It's alright here" and another commented, "The care has been marvellous." One relative referred to a nearby member of staff saying, "She's a lovely soul." They also told us that their relative was well looked after, was always clean and their room was always nice. Other comments from relatives described staff as "very good", "caring and more than willing" and "extremely caring."

We spent some time in communal areas and observed the care provided to people and their interactions with staff. We saw staff were respectful, attentive and generally knew people very well. We heard staff members speak clearly and explain what they were doing, for example when using a hoist for transferring a person into a chair. At other times, we observed staff provided meaningful interaction. For example, we saw members of staff sitting and chatting with people, holding people's hands, singing and dancing. Two members of staff supported one person to their room and they were all involved in a friendly conversation and smiling.

When people were supported to walk or transfer from their wheelchair, they were not rushed but supported to move at a pace that was comfortable for them. On one occasion a person was calling out for support. We observed a staff member communicated effectively with them and responded promptly to their needs. The person wanted to move position in their chair and a second member of staff came to assist.

Staff demonstrated a good understanding of what was important to people and how they liked their care to be provided. Staff gave examples of how they supported people to make choices. Some of these included the clothes they chose to wear and what activities they may like to participate in.

One staff member told us, "People are asked what they want to do, such as what time they want to get up or go to bed." Another staff member described how they recognised when a person living with dementia became restless and engaged them in tasks such as laying the table or accompanying them for a walk.

Relatives and visitors we spoke with felt they were involved with their family members' care. They said they were always made to feel welcome by staff and we saw examples of staff greeting visitors and facilitating their visits to be more private. One visitor told us they could visit whenever they liked or telephone staff for information about how their relative was. Visitors told us they were invited to social events such as parties and other celebrations. Records confirmed that staff supported people to maintain relationships and social links with those that are close to them.

Staff knew the importance of respecting people's diverse needs and choices. For example, one staff member explained they always asked a person their preferences for care and how they respected one person's choice for gender of staff. Care records included details about people's ethnicity, preferred faith and culture. People were provided with cultural foods of their choice and supported to follow their chosen faith.

Records showed that there had been discussions with people regarding their personal wishes in relation to end of life care. We saw examples of 'do not attempt resuscitation' (DNAR) agreements in place. DNAR are decisions made in relation to whether people who are very ill and unwell would want to be resuscitated or would benefit from being resuscitated, if they stopped breathing. Records we sampled evidenced that decisions had been made appropriately and in agreement with the person's family and GP. Nurses told us they were undertaking training in end of life care.

People looked well cared for and had been supported with their personal care needs and personal preferences. We saw in all but two cases people were appropriately dressed. One relative described staff as "always attentive" to their family member's personal hygiene. On one occasion we were told by a visitor that their relative was wearing clothing belonging to another person. They told us that their relative had always been particular about their appearance and would be embarrassed by what she was

Good

Is the service caring?

wearing. The visitor said they would speak with the manager who would sort it out. We saw a person wearing trousers that were far too short and brought this to the attention of the operations manager.

People who could comment said staff respected their privacy. All rooms at the home were used for single occupancy. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people feel at home. However, during our walk round the premises we saw that none of the bedrooms had door locks and these had been removed. This meant people did not have the option to lock their bedroom door for privacy or choice. We discussed this with the operations manager who agreed that some people using the service may choose to hold their own key. Following our inspection they told us that nobody using the service expressed an interest in having a key but appropriate locks would be fitted if the need arose.

Staff understood the need to maintain people's privacy and dignity and were able to tell us the action they took to ensure this. They told us they always knocked on doors and waited for a response before entering people's rooms. Staff explained how they upheld individuals' dignity. One staff told us they made sure people were offered an apron or napkin when eating and that doors were kept closed when people required personal care. Another staff member said that they made sure a person was covered as they sometimes walked off in a state of undress. We observed staff use privacy screens in communal areas when they supported people to transfer by hoist. We saw this happen consistently on three occasions and a visitor confirmed that this was a regular occurrence.

Requires Improvement

Is the service responsive?

Our findings

People's care was not planned in a way that reflected their individual needs. We found that the quality of information contained in the care records was variable. There was a lack of detail to personalise care plans which were out of date and did not always reflect people's changing needs. For example, we saw that one person's moving and handling plan had not been reviewed since July 2014. Prior to this time there was evidence of a monthly review from December 2013, but entries made by staff were brief and repeated each time as, "care plan ongoing- is on pressure relieving mattress." In other files care plans had not been reviewed since October 2014. Care plans outlined the areas where people needed support, but provided little information about people's preferences or personal history. They were mainly task orientated and lacked personalisation. Sections for life story and lifestyle in care files we looked at were blank in some cases and there was only brief information about individual backgrounds recorded in the admission assessments. The operations manager was aware of these shortfalls because a quality assurance manager had recently carried out a full audit of people's care documentation and found similar issues. We were shown a copy of their report which identified that different records needed updating for everyone using the service. Following our inspection we were advised that nurses and care staff were in the process of addressing this and a quality manager from another one of the provider's care homes had been asked to support the process.

We found that people's care needs were not reassessed regularly, which put them at risk of inconsistent care and/or not receiving the care and support they need. With care plans being out of date and not reflecting people's current needs, it also meant that the staff might be using the wrong information when they are caring for people. We were therefore not assured that people using the service experienced the care and support they required as staff were not provided with clear and accurate information about their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records showed that needs assessments took place before people moved to Wells Place, with relatives and health professionals supporting the process where possible. One relative told us, "They did a good assessment initially." These assessments provided relevant social and healthcare information and where appropriate, included information provided by Social Services. We looked at an assessment for a person who had recently moved in. This showed evidence of improvements in how people's care was recorded. The initial assessment considered all aspects of the person's life, including their strengths, hobbies, social needs, preferences, health and personal care needs and areas of independence. It included details of specific care areas such as nutrition, skin care and mobility and was written in the first person. There was a life history profile that covered key areas and events in the person's life such as their childhood, adulthood and retirement. There were also records to show that people and relatives were involved in this process and able to comment on what was planned. The operations manager told us they would use this example as a benchmark for improving other people's care plans.

People were provided with a range of activities to meet their needs and chosen interests. The provider employed an activities co-ordinator who worked five days a week. We received positive feedback about them. One relative told us, "The co-ordinator is always doing things to stimulate people even when they can't cooperate." They said their family member went on a recent museum trip and told us about other activities people took part in such as bingo, snakes and ladders, art and craft, shopping trips and "remember when" reminiscence sessions. During the inspection there was a variety of activities taking place in one of the two lounges. We saw individuals were supported to make photo frames using art and craft materials and participate in painting activities. There was an information file about available activities in the home and community. This contained photos for people to look at and help them choose what they would like to do. Parties were held to celebrate birthdays and special occasions. People told us they the home often arranged for live musical entertainment which they enjoyed. In the paved rear garden, raised flowerbeds had been installed to enable people in the home to actively participate in gardening. A member of care staff described activities as "very, very good, there are always regular events."

Our structured observation in the main lounge showed that some people using the service may have benefitted from more engagement and stimulation. There were seven people sitting in the main lounge. The television was on very loud but nobody was watching it. Four people were

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asleep, others appeared withdrawn and in a neutral mood state. A member of staff came into the room, turned off the television and put on some soft music. This had a positive impact for people who responded by smiling when the music was played in the background. We noted however that aside from magazines, there was nothing in the lounge environment that people could engage with such as memory boxes or sensory equipment. We discussed this with the operations manager who told us the service was looking at ways of improving the environment for people living with dementia. For example, there were plans to put up more pictures to stimulate conversation about people or key events from a bygone age.

We recommend that the service refers to current best practice guidance around activities for people living with dementia such as the resource toolkit for living well through activity in care homes produced by the College of Occupational Therapists.

People were encouraged to share their views and experiences of the service by taking part in meetings and through daily discussions with staff and management. Resident and relatives meetings were also held on a quarterly basis. One relative said they found these beneficial because, "we can speak our mind." We reviewed minutes the most recent meeting which included a discussion about a staff key working system and improving communication and laundry arrangements. Minutes showed that relatives were able to express their views openly and the service took action where needed. Although there were meetings for people and relatives, they were not provided with written questionnaires to feedback their experiences. The provider was in the process of addressing this however and showed us a blank copy of a prepared form. In the entrance hall comment cards were available to people and visitors. Following our inspection, the provider sent us a summary of findings. The results showed that, people who participated were very satisfied with the care and services provided.

Individuals we spoke with and visiting relatives were confident the staff and registered manager would listen and act on any concerns or complaints. One relative said, "Never had any complaints." Another relative said, "Can't find any fault at all." Relatives gave examples where the manager had responded and resolved issues they raised. These included improving laundry arrangements and promptly arranging for a doctor to review a person's medicines.

Although a copy of the complaints procedure was displayed on a notice board, it was produced in small print and not available in any other format. We brought this to the attention of the operations manager as people using the service had different needs including visual and cognitive impairment. They agreed to review the procedure and improve its accessibility for people.

When we checked the records to see how complaints or concerns were managed, no record of complaints had been made since October 2013. A complaints process was in place but we found that not all concerns had been recorded. Following our inspection the registered manager sent us a summary of complaints and the actions taken. This showed that complaints had been resolved to people's satisfaction.

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Our findings

The home had an extensive quality assurance system for monitoring all aspects of the service provided to people. This was a formal system in place for all of the provider's establishments. It included monthly manager meetings and compliance reports and monthly audits to assess how well the service was running. These audits were based on the new inspection approach and five key questions set by the Care Quality Commission. They also included data about the number of complaints, accidents and incidents, staffing hours, vacancies and turnover. The monthly manager audit reports between January and May 2015 were provided after our inspection. However, we found they included recurrent themes and limited evidence that actions had been addressed. For example, it was recorded each month that 48% of staff were compliant with mandatory training and that "all files need updating and more thorough detail" for people's care documentation. Another repeated action included, "I'm going to attempt all supervision based on training." Over the five months, the registered manager had similarly recorded other actions which included advertising a staff post internally for a champion in dignity and palliative care.

Other audit records showed there were inconsistencies in monitoring the service quality and acting on any identified shortfalls. For example, a medicine audit undertaken in March 2015 found that PRN protocols for people needed reviewing and updating. The same action was recorded for April and May 2015.

The registered provider told us he regularly visited the home and had identified some environmental improvements were needed following the most recent visit in April 2015. Although there was detailed information about what action was required, there was no written development plan or records to show how actions were being addressed. It was therefore unclear how the provider checked whether necessary changes were made. There was also no overall plan that identified the strengths and weaknesses in the service and any planned improvements. This meant it was unclear how the service monitored its performance and made improvements based upon the views of people using the service, their relatives and other stakeholders involved with the home.

We therefore found that the provider's governance systems were not always applied in the home and they had not identified the issues that we found during the inspection. This meant the systems used to monitor, review and assess the service were not always effective.

We also found that record keeping in the home was inconsistent across a number of areas. During the inspection, records required to be kept by the service were not readily available or missing. For example, records of staff supervision, the most recent audits and meetings held for people and their relatives were not available. We were told that the registered manager kept these records electronically and they were password protected. The different recording systems meant that records were difficult to use and access. The operations manager acknowledged that records should be accessible in the event of the manager's absence and told us this would be addressed.

Staff records and other records relevant to the management of the services were not always accurate and fit for purpose. Staff training and supervision information was kept in several places and was incomplete or unavailable. The staff allocation rota records we reviewed for May and June 2015 were not clear and legible. These contained hand written changes and loose pieces of paper attached to the rota outlining a list of dates and numbers of staff required. Rotas did not identify the full names of the staff or who was in charge. They also did not reflect when the registered manager was working. Although the manager had dealt with a number of minor concerns raised by relatives, no records were available of the concerns or of any action taken and outcomes since the last recorded complaint in 2013.

The lack of clear and contemporaneous records regarding people's plans of care meant there was a risk people may not receive support that was personalised to their individual needs.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visits, the registered provider and operations manager engaged with people, visitors and staff throughout the day. The registered manager was on leave at the time of our inspection. We received positive comments from relatives about their leadership style. One

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relative described the manager as, “very direct, open and honest.” Another told us, “She is caring, always listens and deals with things immediately.” A third relative said if there was a problem, “She will always come and help.”

Although staff had not received regular formal supervision, many felt supported by the management and able to discuss any issues. They told us information about people and the day to day running of the service was shared through face to face handovers and staff meetings. One staff member told us that the operations manager came to speak with staff following a recent safeguarding incident. They said, “We talked about lessons learnt and had time to reflect.” Minutes of a staff meeting held in May 2015 included clear discussions about people's needs, the day-to-day running of the service and any planned improvements. Staff were aware of the whistleblowing policy and were confident to report bad practice. One staff member told us, “If someone was in danger, I’m not afraid to report it.”

Accidents were being documented to give an overview of what had happened and the action taken to prevent a reoccurrence. Any untoward incidents or events at the service were reported appropriately and action was taken to minimise the risk of them happening again. The registered manager shared information with outside agencies like the CQC and the local authority. Management and staff worked positively with external professionals and had been working in collaboration with the local authority safeguarding team in response to the concerns which had been raised.

Shortly after our inspection the operations manager sent us written evidence that they had begun to improve the systems for checking the quality of the service. This showed that the provider acknowledged improvements were needed and had taken prompt action to address our concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not always protected from unsafe care or treatment because the registered person had not done all that was reasonably practicable to assess and mitigate identified risks to them.** Regulation 12 (2)(a)&(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not made suitable arrangements to ensure people's care and treatment met their needs and preferences.** Regulation 9 (1)&(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided to people. Systems were not used effectively to evaluate and improve practice.** Regulation 17(1)&(2)(a)&(f) **Records of care and treatment provided to people were not consistently accurate or complete. Records relating to the management of the service and staff employed were not accurate, complete or kept securely.** Regulation 17(2)(c)&(d)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People did not receive care and support from staff that were appropriately trained or supervised to effectively carry out their role. Regulation 18 (2)(a)