

Ultima Care Centres (No 1) Limited

The Meadows Care Home

Inspection report

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25 July 2018

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 23 and 25 July 2018 and was unannounced

The Meadows is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided. The Meadows provides care for up to 69 people some of whom are living with dementia. At the time of our inspection 39 people were living at the service.

The home did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The manager had recently submitted their application to CQC for consideration and approval to become the registered manager. On the day of the inspection the manager was on annual leave.

The service is currently in the process of transitioning to a new provider. At present the new provider has daily oversight and management responsibility for the running of the service. However, the current provider remains legally responsible for the service until the sale of the service is completed.

Following the last inspection, we found that the provider was in breach of regulation 17 (Good Governance). We asked the provider to complete an action plan to show what they would do and by when to address those issues identified.

At this inspection we saw that the provider had not taken appropriate action and the breach identified at our last inspection had not been addressed. This has resulted in a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we also found breaches of regulations 9 (Person-centred care), 10 (Dignity and respect) and 18 (Staffing).

Care planning did not always examine the needs of people who used the service. Risk assessments and outcomes of these assessments were not person-centred in order to achieve positive outcomes for people.

We reviewed training records and found that 28% of training was out of date and that staff were not always supported with an appropriate induction once they commenced employment. Supervisions and appraisals were not always carried out, this was supported by records and also in discussions with staff.

The provider did not have a robust quality assurance process in place to check the quality of care provided and to drive necessary improvements.

Care provided did not always maintain people's dignity.

You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives confirmed they felt safe living at The Meadows. They spoke highly of staff and care delivered and staff knew the people they care for very well.

Staff followed the provider's procedures for safeguarding and were able to explain how they would keep people safe from harm or abuse. The provider had a recruitment process in place to ensure that only people who were suitable to work with vulnerable people were employed.

During both days of the inspection staffing levels were observed to be sufficient to meet the needs of people using the service. This was supported by a review of previous staffing rotas.

The service was undergoing a refurbishment. The provider was currently refurbishing two communal areas of the service, one into a 'bar' and the other into a 'tea shop'. On the first day of the inspection we identified an issue with regards to refurbishment of the service and the use of unsafe equipment. This included a lack of a risk assessment regarding contractors being on site. We also saw electrical equipment in use which had been classed as unsafe for use following a portable electrical test (PAT) carried out on 8 June 2018.

Staff understood the principles of the Mental Capacity Act, 2005 (MCA) and ensured they gained people's consent before providing personal care and support. People were encouraged to be involved in decisions about their care.

Activities played a big part of daily life at the service and the provider employed a dedicated activities co-ordinator to support this. Internal and external activities were provided which people living at the service spoke very highly of. The activities co-ordinator had been very creative in their design of various activities which had a beneficial impact on people living at the service.

A complaints procedure was available and people were able to provide feedback of their views of the service. This included the opportunity for attendance at resident's and relative's meetings.

Staff that we spoke to confirmed that the manager was both supportive and approachable and very much hands on.

Lunchtime was a very pleasant and relaxed experience. The menu was varied and the food being served looked very appetising, was nicely presented and portions were of a good size. Staff asked people their preference prior to serving lunch. Staff supported people as necessary and encouraged people who were more independent.

Overall the premises were sufficiently clean, and the provider had a system in place to manage clean and dirty laundry. We saw that staff had access to personal protective equipment (PPE), and used this for the various tasks they carried out.

Certain areas of the service were very dementia friendly. For example, a reminiscence lounge on the first floor which contained lots of old artefacts which supported and encouraged conversation amongst people living with dementia. There was signage to help people find their way around and identify their own rooms.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Some appliances had been deemed as unsafe but remained in use.

The service was undergoing refurbishment. However, no suitable risk assessment was in place for this process.

Doors that should have been locked were not locked. This allowed access to confidential information and hazardous substances.

Staffing levels were found to be appropriate to meet the needs of people living at the service

Requires Improvement ●

Is the service effective?

The service was not always effective.

The provider did not have effective systems to support staff in terms of their supervision.

Staff training records showed essential training had not taken place.

The provider was working within principles of the Mental Health Act (MCA).

Requires Improvement ●

Is the service caring?

The service was not always caring.

We observed incidents whereby people's dignity was compromised.

Staff approaches and interactions with people and relatives were very positive.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Requires Improvement ●

Care plans were not updated to include changes in people's needs.

Care plans were not detailed enough to allow staff to be able to support people in a caring way.

Activities were varied and well-organised.

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

Is the service well-led?

The service was not always well-led.

Previous issues identified from the last inspection which had resulted in a breach of regulations had not been actioned.

A range of audit systems were in place. However, some audits were found to be ineffective.

The manager at the service was not yet registered.

Staff told us they felt supported by the manager

Requires Improvement 

The Meadows 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 23 July 2018 and was unannounced. A second day of inspection took place on 25 July 2018 which was announced.

The inspection team was made up of two inspectors, one specialist advisor who was a nurse and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority commissioning team, Clinical Commissioning Group (CCG) and the safeguarding adult's team. We reviewed the local Healthwatch website for information regarding The Meadows. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

A new provider was in the process of purchasing The Meadows. During the purchase period a management agreement had been made, whereby the new provider had day-to-day management responsibility and oversight of the service. However, at the time leading up to and during inspection and purchase period, Ultima Care Centres (No 1) Limited remained registered and was responsible for the service.

During the inspection regional managers and the managing director from the new provider were on site.

We spoke with 13 people living at the service and seven relatives. Also, with two regional managers, one managing director, and 13 members of staff of which three were nurses, one caretaker, seven care workers, one activities co-ordinator, and one ancillary staff.

We pathway tracked four people who were receiving a service, including their care and medicine records. We reviewed four staff files regarding recruitment and looked at staff supervision and training information.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

We observed one person on the first day of inspection showing both physical and verbal signs of distress. The staff member present told us, "(Person) always gets upset during personal care." This member of staff tried to calm the person down as did another member of staff, without success. The managing director intervened and began to speak to the person using appropriate techniques, at which point the person became calmer.

We reviewed this person's care plan and it did not include information to guide staff about triggers or the most effective strategies to use when the person showed signs of agitation. The care plan consistently included information about them becoming anxious during personal care. However, there was no evidence to show staff had reflected or analysed this to identify what it was about personal care that caused distress, what worked, what did not work and what need to change. There was no evidence staff had referred to specialists for advice and guidance. There was a 'distressed behaviour record' for the person which was very brief. The document had boxes for what could be done differently and external professional input, but these were blank.

This constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke to the managing director regarding what we had found in (person's) care plan and asked that this care plan be reviewed as a high priority.

The service was undergoing refurbishment. On the first day of inspection decorators were on site. No signage or hazard boards were visible to notify people of this. Cans of paint, equipment and cleaning products were being stored in two (unused) bedrooms. Both bedrooms doors were open and therefore accessible to people living at the service. This was immediately brought to the attention of the regional manager who arranged for these doors to be locked.

We asked the regional manager for a copy of the painting and decorating risk assessment which should have been completed prior to work commencing. We were later informed that a risk assessment had not been completed. The managing director agreed to complete a risk assessment as a matter of urgency. The risk assessment was provided to us on the second day of inspection.

We found a plug which was in use in a person's bedroom which had a sticker on stating 'failed do not use'. This sticker was issued following a Portable Appliance Test (PAT testing is the examination of electrical appliances and equipment to ensure they are safe to use). The PAT test report was dated 12 June 2018. We brought this to the attention of the regional manager who agreed to address this issue as a matter of urgency. This equipment was removed by the end of the day.

One relative told us, "My (person's name) bed has been broken since June and we are still awaiting a replacement. We brought this to the attention of the managing director. One the second day of inspection

we were informed that the spare part had been ordered for the bed and it would be fixed the following day.

We found a number of unlocked doors which should have been locked for people's safety and confidentiality reasons. One was the nurse's office which held people's personal care plans and confidential information. Other doors included the sluice room and a staff room which contained cleaning products and staff's personal items. This posed a risk of people living at the service gaining access to products which if ingested could cause them harm.

People we spoke with told us they felt safe living at The Meadows. Comments included, "Yes, I'm safe in every way. I trust the care staff." One person told us they had experienced a recent bereavement and the staff had been wonderful. Another person told us, "I can't walk and they do everything for me, I don't lock my door at night as I feel safer if the door is open and nothing ever goes missing. It only closes when the alarm goes off." Other comments were, "Here, there is always enough staff available to hear me," and, "Yes, safe in every way, here I lack nothing and the staff come straight away when I press my buzzer."

We reviewed staffing rotas for both ancillary staff and carers, and on both days of inspection staffing levels were appropriate for the needs of people living at the service. The provider also uses a dependency tool which calculates the required number of staffing hours.

Staff we spoke with told us, "Yes, some staff had been brought out of the laundry to assist domestic staff." Another staff member told us, "Yes, enough staff to do the job, but personally I would like extra staff to be here to be able to go on outings with people." Through observation and through looking at rotas we deemed that staffing levels were sufficient to meet people's care needs in a safe way.

We saw that people were supported and when they called for assistance either vocally or via their buzzers, staff responded efficiently. One relative told us, "You could always have more staff, however, there always seems to be enough staff on call when I visit." We asked one person if they felt there were enough staff to support them and they told us, "Oh yes, I'm showered frequently, they could do with more staff on a morning sometimes. I can get up or go to bed when I want."

The service had an up-to-date policy regarding safeguarding and staff. spoke confidently about their role in protecting people. A number of safeguarding issues had been raised since the last inspection, with appropriate referrals. made to the local safeguarding adults authority.

We reviewed four staff recruitment files. We saw the provider ensured checks had been carried out before new staff started work. These included checks from the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working within a care setting. The provider had a process in place for checking the professional registration of all nursing staff working at the service.

We found that the provider had safe and robust processes in place for medicines. This included the storage, handling, stock and recording of medicines for people. We observed staff administering medicines using techniques which were safe.

The home was clean and tidy. Domestic staff were on duty and told us that they had access to appropriate cleaning materials and personal protective equipment.

We saw that regular and satisfactory checks had been undertaken with regards to the safety of the premises and equipment which was used at the service.

Is the service effective?

Our findings

We reviewed staff training records to see if staff had completed the necessary training and to see if they had the skills and knowledge to provide people with safe care. Records reviewed identified essential training which included induction, fire safety, moving and handling. We identified gaps in essential training for some staff. For example, one member of staff had not completed any of the essential training courses including moving and handling. The only training course they had completed was safe management of medicines. This person was in charge of the service when we arrived on the first day of inspection.

We spoke with the regional manager regarding this issue and were told that training had been arranged for this person but they had failed to attend on two previous occasions. The provider had not up to the point of inspection, taken steps to address this issue. The regional manager agreed to arrange training for this member of staff as a matter of urgency.

Training records had not been monitored or maintained to a sufficient level. The provider's induction policy for staff stated that all staff should go through an induction on day one and two upon commencement of their employment. Records reviewed showed that 13 or 28% of staff, had not attended an induction. Induction plays an important part in staff training as it includes vital information that staff need to know to allow them to care for people safely and effectively.

Records reviewed showed that training had not been carried out to the required level. Provider audits dating back to November 2017 identified that training was not at the provider's own required completion level of 85%. One month (March 2018), stated training was at 22%.

The provider did not have effective systems to support staff in terms of their supervision. We found no records to review regarding appraisals. An appraisal is an annual review of staff performance. We spoke with one member of staff who told us they had not had a formal yearly appraisal, nor had they had any supervision meetings since they began working at the service. Supervisions allow the manager to discuss with staff any performance issues, any training requirements which may be highlighted, along with further personal development.

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

Lunchtime was a relaxed and pleasant experience, no one was rushed and people took their time. Dining tables were nicely laid with tablecloths and were set with contrasting plates and cups. The lunchtime menu offered people the choice of sausage casserole, or steak pie and vegetables followed by semolina or yoghurt. Water, juice and warm drinks were available for people to choose from.

Staff were seen to ask each person their preference for lunch. Staff did this by showing people a small portion of each dish to allow them to make their choice. For people living with dementia it is recognised that the use of pictorial menus or 'show and tell' techniques is more beneficial in allowing the person to choose

and understand the choice they have made. Staff were seen to encourage people to eat independently and people were asked if they would like any more to eat. Some people chose to have their lunch in their room. Those people who decided they didn't want their original choice were offered alternatives. We asked people if they enjoyed their food. One person told us, "Yes, I like breakfast best. It's beautifully prepared and there are plenty of drinks water, tea and juice." Another person told us, "Yes, I have no problem with eating, it's very difficult losing weight here, I'm probably putting weight on."

Hydration stations were available throughout the service for people to access themselves and this was further supported by regular 'tea/coffee rounds.'

People and relatives we spoke with told us they thought staff were trained to be able to meet their needs or their family member`s needs. One person said, "Yes, they do everything very well from what I see and I see them every day, I get plenty of drinks, there is fruit if you want, I have a fridge and I get a half of beer every night. I have no complaints whatsoever as they are helpful getting me out of my chair as I can't walk and would fall over, they help me go to the toilet, shower me, they do everything really." Another relative told us, "I observe them constantly, they are definitely caring and well trained."

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The DoLS matrix and accompanying records showed all DoLS had either been authorised or were waiting for authorisation. Applications had been made to renew those that had expired.

We saw that consent forms were completed by people who used the service or their representatives as appropriate. People's capacity to make everyday decisions was assessed and more significant decision making was undertaken with other professionals and representatives to ensure decisions were made in people's best interests. Some individuals were subject to DoLS authorisations and staff understood the reasons behind them and their implementation. However, as part of reviewing one person's care plan, we saw that (person) had bedrails in place but there was no MCA/best interest decision recorded for this. This person also had a bedrail assessment in their care plan which was in-complete.

Accidents and incidents were recorded and notified to the appropriate authorities. For example, where people had fallen, a review had taken place and where necessary referrals were made to the Falls Team. The falls team are based in local hospitals and are specialists in assessing people who may be at risk of falling. They provide advice, guidance and action plans to best support and prevent where possible, further falls.

The provider had adapted some areas of the home to meet the needs of people living with dementia. For example, there was a reminiscence lounge on the first floor which was home to an old-fashioned piano, a china cabinet with ornaments, an old cine-machine and lots of old artefacts. This type of environment is important to people living with dementia as it can stimulate and encourage discussions about their past and what is meaningful to them.

Further improvements were underway and as part of the refurbishment programme, the provider has commenced creating two new 'themed' communal areas. One was going to be a bar and the other a tea room. The manager had involved both people, their families and staff in this programme.

Some corridors had murals painted on the walls, one of which depicted a flower shop. The corridors were wide with some clear signage. Handrails were clearly identified and the walls held such things as textile pictures, flowers in pots, and hats. All of these areas were bright and safe for residents to explore, remove and use.

The music room on the ground floor had two main walls covered in old sheet music along with pictures of music artists. The activities co-ordinator had made a 'dummy' Wurlitzer which stood in the corner of the room from which music was played through a discreet speaker.

People's rooms were decorated in a homely fashion and had been personalised with ornaments, family photographs, personal belongings and soft furnishings. Each room had an en-suite which had a toilet and hand basin.

Is the service caring?

Our findings

NHS England issued guidance entitled 'Heatwave plan for England'. This guidance outlines steps providers can take to ensure that people remain comfortable and healthy in extreme warm weather conditions. We saw that the provider had displayed in their foyer, a document from Public Health England, titled 'Hot Weather Alert Level 2' for North East England, which was dated 25 June 2018. The guidance includes ways in which providers can ensure that vulnerable people remain comfortable during times of extreme weather, without compromising their dignity. However, we found some examples where staff had not always acted appropriately to ensure people maintained a comfortable body temperature in a way that maintained their dignity.

On the first day of inspection it was a very warm day. During a walk-around of the premises we noticed someone lying on their bed. Their legs were bare and exposed and the door to their room was wide open. They were in a state of undress with only their upper body covered and nothing on their lower half other than an incontinence pad. When we approached this person to ask if they were okay, they told us they were warm. We asked a member of staff to come and assist them with their dignity and was told, "(Person) kicks the sheet off." The member of staff then placed a folded heavy duvet over the person's legs.

Later in the day in the upstairs lounge we saw another person lying in their bespoke reclining wheelchair. This person's nightclothes were around their waist and again, this person's lower half was fully exposed and they were wearing an incontinence pad. During this time other people were in this lounge and a visiting relative also entered the room. A staff member told us, "(Person) had kicked the sheet off because they were warm." They then took this person back to their room to adjust their nightclothes.

On both occasions above, people's dignity and respect had been compromised. We brought both of these instances to the attention of the regional manager who told us they would look into this as a priority.

This constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some staff had worked at the service for a long time and it was evident that as a result of this, they knew people they cared for very well. They were able to tell us about people's life history, their likes and dislikes. People told us that care provided at the home was good and one person we spoke with told us, "Yes, they are good and whilst taking me to the toilet or the shower they are very understanding. They encourage me to do what I can as I can't walk. I wouldn't like to be anywhere else. I'm happy here, this is my home. At (spouse's) funeral, half of the staff came. It was very emotional but showed just how much they cared." Another person told us, "Yes, I'm well cared for, they know their duties and jobs. They are very good, they chat away and listen and if I'm poorly I see a nurse and then a doctor straight away."

When we asked staff if they liked working at The Meadows one staff member told us, "I love it! I talk to people as if they are part of your family, extended family. When I go into (person's) room, I always chatter on, and (person) asks me for a duster. (Person) starts dusting things down and then after a while will say, 'Right,

I've had enough now I want to hand my notice in!' I know how important doing this sort of thing is to (person)." Another member of staff told us, "I like working here and I have worked in other care environments but this place means I can do the very best for my residents because they deserve it."

We saw that people were clean in terms of both their personal cleanliness and their clothes and they were well dressed.

During lunch-time and activities later in the day, we observed some lovely interactions between staff and people. Both engaged in relaxed and happy chatter, with lots of laughter and hugs. Staff were seen to offer support to people without being intrusive. Gentle encouragement was provided at lunchtime and people responded well to this with lots of smiles and nods.

During an afternoon activity in the ground floor lounge, staff were sat with people and we saw that people sought comfort from holding hands with staff. We saw that people really enjoyed and engaged with this singing activity and staff sat comfortably with people, offering reassurance when this was sought.

One person was waiting in their wheelchair in reception to go to a medical appointment and we observed that every member of staff who came into reception stopped and chatted with them, with conversations turning into laughter.

Is the service responsive?

Our findings

The provider had identified that people's care plans required improvement. All care plans on the first floor had been reviewed and re-written, and plans were in place to commence a review of people's care plans on the ground floor.

However, one care plan that had been reviewed did not reflect the current needs or the level of detail required to ensure that this person received the care they needed. For example, they had been identified as 'very high risk' following a Waterlow Assessment. This 'assessment' is used to determine if people may be at risk of developing damage to their skin. As a result of the assessment, this person's care plan evaluation showed they had been prescribed cream to be applied twice per day, but the care plan had not been updated to reflect this change.

We reviewed six care plans during the inspection. Some showed sufficient detail and information which would support staff in their delivery of care for people. They contained information such as people's like and dislikes, and how staff should care for them. The care files also contained lots of information from fellow professionals and outside agencies. This included discharge information from hospitals and care plans from social services. Catering and dietary information was detailed, of which the kitchen received a written copy. Speech and Language Team (SALT) guidelines were also incorporated into care plans. Past medical history details and baseline observations were recorded. This is important information should the person become unwell and emergency or urgent care services are required. End of life care was also included in people's care plans along with documented risk assessments for example regarding falls, choking and moving and handling.

Other care plans reviewed showed there was evidence of various professionals involved with people's care, for example GPs, dieticians, and vision care. Their visits were recorded and any advice or treatments were incorporated into care planning. Personal evacuation plans (PEEPs) were in place for people and they had recently been evaluated.

There was access to a nurse call system in every area of the home. From observations staff responded in a timely manner, and also to verbal requests for assistance or support with cheerful professionalism and with care and consideration. A senior care worker described very good relationships with the visiting district nurses and how they responded quickly either to give direct treatment or to discuss what actions staff needed to take.

The service employed a dedicated activities co-ordinator. Activities were a focal point and we saw promotion of a forthcoming summer fete. An activities board was visible in the foyer, which allowed people to see what was happening. Indoor activities included group sing-a-longs, Mister Lickety (an ice cream trolley), music therapy (1:1), arts and crafts, spin the wheel, baking and a bird observatory. Outside activities included the use of a beach hut (sited in one of the gardens). Staff served ice-cream from this hut to people when sitting outside in the garden. Other activities included crazy golf, badminton, croquet and gardening.

The activities co-ordinator told us, "I put packages of activities together and the manager lets me get on with it". They told us they often undertook 'one to ones' with people who were bed bound and unable to join in with group activities. This included either singing or just sitting in peoples' rooms playing therapeutic guitar music. They said, "(Person) hadn't spoken properly for weeks on end. I started to visit them on a regular basis and they began to sing Doris Day songs word for word. They would often ask where the person with the guitar was."

They told us about one person who used to be a 'roadie' for Dusty Springfield and the Everly Brothers. As a result of learning this, they had created a trolley for them, which held dummy roadie boxes, and 'gig' sheets. This person used to walk up and down with their 'gig gear' which gave them great satisfaction and allowed them to reminisce about a time when they did this role for a living.

One person we spoke with said, "I like bingo and all of the activities." Another added, "I like the singing, bingo, and watching TV."

During the inspection, we sat in the lounge and observed a group of ten people engaged in a sing-a-long with the activities co-ordinator and other members of staff. People and staff were singing. There was a lot of laughter and it was clear that people were engaged and really enjoyed being part of this.

Most people we spoke with were happy that the staff knew what care they needed and did not feel they needed to be involved in their care planning or reviews. Some people had been to the relative / resident meetings.

People we spoke with knew how to raise a complaint, for example one person told us, "Complaints? It's the opposite in fact. No one has anything to complain about."

Information regarding advocacy services was available to people, relatives and visitors. Advocates help to ensure that people's views and preferences are heard.

We reviewed the provider's complaints file alongside their own policy. We saw that complaints were responded to and, as the file held only a few complaints, it was not possible for the provider to carry out an analysis of themes. A compliments book was held in reception. This book contained thank you cards from relatives for the care and kindness staff had shown and provided to their loved ones.

People's rights to hold religious beliefs were respected. One relative we spoke with told us that people received Holy Communion from a visiting priest.

Is the service well-led?

Our findings

At our last inspection, we identified a breach of Regulation 17 which related to systems and processes not being effectively operated. Records were not always accurate or completed in respect of each service user. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to address those issues identified. At this inspection we saw that the provider had not taken appropriate action and the breach identified at our last inspection had not been addressed.

Care plan audits, although carried out, were not robust enough and did not include any record of when actions had been met. We identified flaws in care planning documentation that had not been acted upon by the provider.

One person's care plan had been audited on 29 June 2018. The identified action was that all care plans for this person needed to be re-written and a timescale of 72 hours was set. At the time of inspection these had not been signed off as having been re-written and those care plans that had been reviewed for this person had not been amended.

Multiple governance issues identified during the inspection showed that systems and processes were not being managed in a way that identified and acted on core problems, such as insufficient training and care plans not being sufficiently person centred. This had impacted on people's wellbeing and presented a further risk were it not addressed promptly.

These issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The regional manager has since forwarded us an updated training plan which included arranged dates for all outstanding training with the exception of induction.

On the day of the inspection the manager was on annual leave. The manager had been in post since February 2018 and had applied to CQC, to be the registered manager of the service. Two regional managers and the managing director of the company who was currently managing the service arrived following commencement of the inspection.

The provider had recently carried out a quarterly health and safety audit, which included infection control.

The manager held regular relative and resident's meetings. We saw minutes of these meetings from March, April and May 2018. These meetings included discussion around activities, staff and meals.

We reviewed the providers incidents and accidents file and we found that notifications had been submitted to CQC in line with their legal responsibility.

Staff we spoke to said they felt supported by the manager. One member of staff told us, "Yes I feel

supported, (manager) is just new, it's early days. (Manager) has put things in place that were needed." Another member of staff said, "(Manager) was very hands on and regularly supported staff on the floor working clinically. I find (manager) approachable and very supportive and I am able to contact them at any time should I have any queries or concerns."

Staff meetings were held regularly and nurses in charge held a meeting with heads of departments each day to discuss any issues or information that needed to be shared.

All issues we raised with managers were either acted upon immediately or actions put in place to address going forward. The managing director and regional directors were very receptive to the end of inspection feedback and recognised that there were areas within the service where further improvements were required. They spoke of the ongoing refurbishment plans and how they believed this would have a positive impact on people living at the service. They also told us that they were looking forward to working with and supporting the manager in their role, thus ensuring that issues which had been identified as part of the inspection process, would be actioned and monitored in line with their own policies.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider had not ensured people received care that was appropriate to their needs or preferences.'</p> <p>Regulation 9(1)(2)(b)(c)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 10 HSCA RA Regulations 2014 Dignity and respect</p> <p>The provider had not ensured that people using the service were neglected or left in undignified situations such as those described in the guidance for Regulation 13(4)</p> <p>Regulation 10(1)(2)(a)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured systems and processes effectively operated to ensure compliance with the regulations.</p> <p>Auditing and governance systems were not robust enough to identify the issues we identified during the inspection.</p> <p>Regulation 17(1)(2)(c)(f)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider had not ensured staff received the appropriate training, supervision or appraisal to allow them to carry out their duties.</p> <p>Regulation 18(2)(a)</p>