HC-One Limited

Avandale Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 7, 9 and 12 of March 2018.

The last inspection of the service was carried out on 6 & 7 July 2017 and published on 22 August 2017. At that time the service was rated as good.

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

Avandale Lodge Nursing Home is purpose built and provides care for up to 48 people who require support with nursing and personal care. The service specialises in supporting older people and at the time of the inspection there were 44 people living at the service. Bedrooms are accommodated on the ground and first floor and are all single occupancy with en-suite facilities. There is a lounge, dining room and accessible bathroom facilities on both floors.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had a range of checks in place to monitor the quality and safety of the service such as medication administration records, accident and incident records and people's care plans and monitoring records however these had not always been effective at identifying areas that needed improvement.

The provider had not ensured there was always sufficient numbers of relevantly qualified and experienced staff that had a good understanding of people's needs on duty. The service was heavily reliant on agency staff some of whom had not received an induction to the service. There had been no permanent nurses on duty at night during February 2018 and one night every week there had only been one permanent care assistant on duty.

The administration of medicines was not always safe. The provider could not be assured sufficient time had always been left between the administration of people's morning and lunch time medicines. The guidelines for when 'as and when needed' medicines could be administered to people were not clear. This increased the risk of people not receiving their medicines as they needed them.

Risks to people were not always managed safely. Most people did not have a call bell to use when they needed assistance and sensor mats were not always positioned so they would be activated if the person moved. Risks of people becoming malnourished, developing pressure ulcers and experiencing falls had been assessed but were not always up to date and did not always reflect people's current needs. This

increased the risk of people not receiving care that met their needs.

The mood and behaviour of people with a history of being aggressive to others was not always being monitored. Therefore staff could not identify patterns in behaviour and take action to reduce the risk of incidents occurring. Although pressure relieving equipment was in place for people who had developed pressure sores, repositioning charts showed people were not always being repositioned on a regular basis.

The provider had not ensured that appropriate action to safeguard the people from abuse had always been taken. Incidents of people being verbally and physically aggressive towards others and incidents of poor staff practice had been reported to the registered manager and action taken to protect people from harm. However these incidents had not been always been referred to the local authority for them to consider under local safeguarding procedures or reported to CQC as required.

The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and people were being supported to make decisions in their best interests. However records had not always been completed appropriately.

Each person's needs had been assessed before they moved into the service and a care plan had been developed in consultation with them and their relatives. However these were not always up to date so the provider could not be assured they always accurately reflected people's needs, wishes and preferences.

People were treated with dignity and respect most of the time but people were not always supported by staff who knew them well and had a good understanding of their personalities and personal preferences.

People had the opportunity to participate in group activities that they enjoyed and staff spent time with people in their rooms on a one to one basis. However improvements were needed to increase the range of activities on offer and ensure people were not socially isolated.

People were supported to access to a range of healthcare professionals and their wishes on their end of life care had been discussed with them and documented. People had a choice of nutritious food and drink at meal times and specialist diets were catered for.

The design and adaptation of the building met most people's needs but signage accessible to people living with dementia needed to improve.

A system was in place to ensure people knew how to complain and people were asked for their opinion of the service by way of a satisfaction survey and at resident and relative meetings.

The recruitment of new staff was safe and all staff had received an induction to the service before working unsupervised. Staff felt supported and received the training they needed to undertake their role and support people effectively.

Equipment and premises were safe. There was a plan in place for the safe evacuation of the premises in case of emergency. The environment was clean and hygienic. Staff had access to and used personal protective equipment (PPE) such as gloves and aprons. There were processes in place for the recording of accidents and incidents and these were monitored.

The management team were open and transparent during our inspection and worked with us proactively. During the inspection immediate action was taken to compile and implement an action plan to address the

concerns we had highlighted at this inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had not ensured there was always enough suitably experienced staff on duty to meet people's needs.

The management of medicines was unsafe and risks to people's safety were not always managed well.

Safeguarding concerns had not always been recognised and reported when suspected abuse had occurred.

Recruitment procedures were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Agency staff had not always been provided with the information and guidance they needed to support people safely and effectively.

Staff were aware of the requirements under the Mental Capacity Act (MCA) 2005 and responsibilities under the Deprivation of Liberty Safeguards (DoLS) but records were not always up to date and accurate.

The design and adaptation of the building met most people's needs but signage accessible to people living with dementia needed to improve.

People were supported to access health care support when needed and to have enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always protected from the risk of social isolation or treated with dignity and respect.

People were by kind and caring staff.

People were supported to maintain relationships and visiting was not restricted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not all up to date so staff did not always have the most up to date information on how people wanted to be supported.

People were not always provided with the opportunity to participate in activities that they found stimulating and enjoyable. Regular staff were knowledgeable about people's support needs, interests and preferences and supported them to participate in activities that they enjoyed.

There were systems in place to respond to complaints.

People had the opportunity to discuss their wishes on their end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The providers systems and processes for assessing and monitoring the quality of the services provided and to drive improvement had not always identified areas that needed improvement. Records relating to the management of the service were not all up to date and accurate.

Management were approachable open and transparent and the provider had taken immediate action to address concerns raised at the inspection.

Avandale Lodge Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7, 9 & 12 March 2018 and was unannounced. It was carried out by an adult social care inspector and an assistant inspector on the first day, two adult social care inspectors on the second day and one adult social care inspector on the third day.

We checked our own records to see if there was any information we should consider during this inspection. We looked at the information the service had sent to us as statutory notifications. We also looked at a report on the local Healthwatch website which included findings from their visit to the service in December 2017.

Most people living at the service were unable to provide us with their views due to cognitive impairments so we used the short observational framework for inspection (SOFI). SOFI is a tool developed and used by CQC inspectors to capture the experiences of people who use services who may not be able to express their views for themselves.

We used pathway tracking to follow people's care through from its planning to its delivery. As part of this we looked at 12 people's care plans and daily records, seven people's medication administration records and a range of other records relating to people's care such as food and fluid charts and repositioning charts. We looked at four staff recruitment files, an overview of the training and supervision for all staff and other records relating to the running of the service such as quality assurance documentation.

We spoke with six people, with four relatives, four visiting social care professionals and 20 staff including the managing director, operations director, area director, registered manager, deputy manager who was a

registered nurse, six permanent care staff, four agency care staff, two wellbeing organisers who co-ordinated the activities, a kitchen assistant, a cleaner, the maintenance person, the administrator. We toured the home and observed some care, checked a medication round and observed lunch and other social activities.

Inadequate

Is the service safe?

Our findings

The provider had not ensured there was always sufficient numbers staff on duty to meet people's needs. Relatives were concerned about how many agency staff the service used and the affect this had on the continuity of people's care, particularly at night. One relative commented, "When I leave here in the evening, I worry about the night. I just do not know if [relative's name] will be looked after." Staff duty rotas showed that there had been no permanent nurses on duty at night during February 2018. In addition to this, one night every week there had only been one permanent care assistant on duty and one night all the staff on duty had been agency staff. The registered manager told us they had a large number of staff vacancies that were being covered by the provider's bank staff or agency staff and that where ever possible they used agency staff who had worked at the service before.

The registered manager explained that in order to establish the number of staff needed on each shift they used the provider's dependency tool and that the majority of the time they maintained the level of staffing assessed as needed. They explained the dependency tool took into consideration people's physical needs, for example whether people required two members of staff to support them. However it did not take into consideration people's behavioural and emotional needs. The registered manager told us they had raised this issue with the provider and requested the tool be amended so that it more accurately reflected the time needed to support individuals. Although this had not yet been agreed, the provider had confirmed that from the 28 February 2018 one additional care assistant could be provided at night. This meant there were two nurses and four care assistants working each night. Three days a week there was an additional care assistant working from 6pm to 12am.

Care staff told us despite the provision of an additional member of staff at night they were rushed and people still had to wait for assistance. They explained this was because in addition to attending to people's personal care and transfers they also had to serve drinks and snacks, support people to eat and drink and administer medication. A relative of one person who needs the support of two staff to transfer told us that their loved one often had to wait for two members of staff to be available to support them to go to bed. An agency staff member who provided one to one support to a person that required two staff to support them to transfer also told us that they had to wait a long time for staff to respond to their requests for assistance, Staff confirmed this and explained there were 31 people at the service that required two members of staff to assist them to transfer and although some people were nursed in bed they still needed supporting with personal care and it took a long time to get round everybody. In addition to this at lunch time we heard one person who was in their room calling out for staff assistance for 10 minutes before staff responded to them.

The above evidence demonstrates a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider could not be assured medicines were always administered as prescribed and intended. The guidelines in place for under what circumstances 'as and when needed' (PRN) medicines should be administered were not robust. For example they did not clearly state in what circumstances pain relieving and sedative medications could be administered to people or at what point further advice should be sought

from a healthcare professional. Therefore there was a risk of people not receiving their medicines when they needed them.

The provider could not be assured that people were always receiving their medicines safely. One person's medication care plan stated their medicines should be administered in 'thickened juice'. The MAR for this person stated medicines should be given 'in yogurt or juice' but did not specify the juice needed to be thickened. Therefore there was a risk that if these directions were followed the person would be placed at risk of choking. The care plan for another person stated their medicine should be offered on a spoon with juice. Staff told us this person had been given their medicine crushed and mixed into a bowl of cereal. That meant the person would only receive all their medicine if they ate all their food. There was no evidence in any of the records seen that input had been sought from a pharmacist to check it was safe to crush any of these medicines and mix them into food or dissolve into drink.

Medicines had not always been administered as prescribed. One person had been prescribed a topical cream to be applied every two to three days. The MAR showed it had been applied three times each day. Another person's MAR showed one medicine crossed out. Other records showed a GP had re-prescribed this medicine on the 2 March 2018 but it had not been administered to them.

The provider had not ensured medicines were always administered in a timely manner. Staff told us they administered people's morning medicines from 8.30 am to approximately 10.30 am. However on each day of our inspection we saw medicines were still being given at 11.30. We also saw people's lunch time medicines started to be administered from 1pm. Therefore the provider could not be assured sufficient time had been left between doses.

We noticed that most people did not have a call bell to use when they needed assistance. Staff advised that many people were unable to use the bells due to cognitive impairment and they used sensor mats to help staff respond when people required assistance. However there were no risk assessments in any of the care files we looked at to show how people's ability to use a call bell had been assessed, and we saw no risk assessments relating to managing the risk of people not being able to summon staff. Staff told us they checked people regularly but records did not always reflect this. We saw one person sat in a chair that had its back facing the door to their room. There was no call bell in the room and the sensor mat was at the foot of the bed not in front of the chair the person was sat in.

Risks to people had not always been assessed and managed appropriately. Each person's care records contained risk assessments that had been completed including the risk of them developing pressure ulcers, risk of falls and risk of malnutrition. However these assessments were not always up to date and did not always reflect people's current needs. For example one person's pressure ulcer risk assessment did not reflect that they had developed two pressure ulcers. The risk assessment of another person who had experienced a number of falls had not been updated to reflect this. We noted that the mood and behaviour of people with a history of being aggressive to others was not always being monitored. Therefore there were no formal mechanisms in place for staff to identify any patterns in behaviour and take action to reduce the risk of incidents occurring. One person's care plan and risk assessments stated that for reasons linked to their behaviour they should be supported by two male staff. However we saw they were being supported by one female member of staff.

The registered manager told us seven people had developed pressure ulcers since moving into the service. Although pressure relieving equipment was in place for these people repositioning charts showed people were not always being repositioned on a regular basis.

The above evidence demonstrates a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that appropriate action to safeguard the people from abuse had always been taken. Accident and incident records made reference to incidents of people being verbally and physically aggressive towards others. The immediate action taken to diffuse the situation and keep people safe had been recorded. Similarly when staff had witnessed poor practice and reported this to the registered manager the action taken had been recorded. However some of these incidents had not been referred to the local authority for them to consider under local safeguarding procedures or reported to CQC as required.

The above evidence demonstrates a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were 10 care assistants and one nurse on duty each day from 7am to 7pm. In addition to this the provider also employed two part time wellbeing co-ordinators who provided activities and one to one sessions with people, a maintenance person, administrators and a range of kitchen and domestic staff. The registered manager told us they were having a recruitment drive in order to address the staff shortages and told and were hoping some new staff would start working at the service within the next two weeks. A senior member of the provider's management team also told us they were looking into sharing staff from an adjoining service to cover vacancies and provide more consistency in care.

The provider followed safe recruitment practices and relevant employment checks, such as criminal records checks, proof of identity, right to work in the United Kingdom and appropriate references had been completed before staff began working at the service.

Equipment was safe. There were processes in place for regular checks to be undertaken in relation to the safety of the premises and equipment. Portable electrical appliances were tested to check they were safe to use. Fire-fighting equipment was serviced regularly and the gas safety and insurance certificates were up to date. There was a plan in place for the safe evacuation of the premises in case of emergency including a personal emergency evacuation plan (PEEP) for each person.

There were processes in place for the recording of accidents and incidents and these were monitored. For example we saw that when people had experienced falls a referral had been made to the falls team and preventative measures taken. A senior member of the management team informed us they were at the service to review the care plans for people who had experienced a high number of falls. They told us as a result of this they had made a number of recommendations to reduce the number of falls including requesting some people's medication to be reviewed.

We saw most of the environment was clean and hygienic however we did see some crash mats were dirty and the mattress protector on one bed was badly torn. When these issues were raised with the registered manager they were addressed straight way. Staff had access to and used personal protective equipment (PPE) such as gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

The provider had not always ensured that agency staff were provided with sufficient information about the service and people's care needs before they started work. Agency staff deployed to provide one to one support to three people had not completed an induction to the service or been introduced to people and shown their care plan prior to starting work. When we raised these issues with the registered manager they took immediate action to address them; however it is an area of practice that needs to improve and be sustained.

Staff were supported in their role. The provider had procedures in place for permanent staff to complete an induction to the service to ensure they were competent prior to delivering care to people unsupervised. The registered manager explained staff new to care were also required to complete the Care Certificate. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It is designed to give confidence that workers have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There were systems in place for staff to receive one to one supervision with their line manager at least twice a year at which they could discuss in private their personal and professional development and an annual appraisal of their performance. The provider's overview of when staff had received supervision showed the majority of staff had received supervision and an annual appraisal of their performance.

Staff felt supported by their line manager and their colleagues. They confirmed that they had handover meetings at the start and end of each shift, so they were aware of any issues during the previous shift. We also sat in on two 'Flash meetings'. These daily meetings were attended by the registered manager, deputy manager and heads of department. These provided a forum to pass on to staff any updates and information from the provider, discuss any health and safety concerns, discuss staffing levels and provide staff with the opportunity to raise any concerns with the registered manager.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. Records confirmed applications had been submitted appropriately to the local authority for their authorisation. We saw there was a condition on one person's DOLS that the provider should consider installing a sensor on the person's bedroom door to alert staff if someone entered their room. However there was no sensor on this person's room and we could not see from the records that installing one had been considered.

Staff told people were supported to make their own day to day decisions and that if they were not able to make a decision for example whether to receive medical treatment then their family members and the persons social worker or GP would be consulted. Some people's care plans recorded these decisions as best interest decisions however the documentation to support these decisions and confirm who had been involved in each specific decision was not always clear. Some people's care plans lacked details as to whether people and or their family members had been consulted about restrictive practice such as the use of bed rails. We did not assess that this shortfall had resulted in any harm occurring to people but it is an area of practice that we identified as needing to improve to help make sure that good practices are being followed.

Records showed that the majority of permanent staff, responsible for the delivery of care, had completed training in relation to the MCA and DOLS. Staff told us and we observed they gained consent from people before supporting them and delivering care. For example, the member of staff administering medicines checked with people if they were ready to take their medicines and respected their decision if they refused.

The service provided level access throughout and had fully adapted bathrooms and wet rooms. The first floor was accessible by way of stairs or a lift and there was a range of seating available to meet people's differing needs. The entrance hall was decorated and furnished with the theme of an American diner with jukebox. There was also a post box for people to post letters.

The corridors were wide and bright and clear of any obstacles such as equipment. However orientation for people living with dementia could be difficult as the corridors all looked the same. The signage in corridors to essential areas such as toilets, bath and showers were all dementia friendly and included symbols as well as writing.

Bedroom doors contained numbers and some also included people's names and or pictures to help them identify their room if needed. Outside some rooms a 'feature box' containing photographs and small models was used to show individuals interests and likes however there was little information on display to help people orientate themselves as to the time of day, day of the week or time of year. The registered manager told us this was something they had identified as needing to improve.

People's nutritional needs had been assessed and relevant support had been sought for people who required specialist diets such as soft food for people who had swallowing difficulties. Staff told us they provided meals based on people's dietary needs and we saw that they had detailed information regarding the nutritional needs for people with varying requirements. They were currently providing meals to meet people's individual needs, such as a diabetic diet, pureed and fortified diets. We observed people having lunch on each day of the inspection and staff were seen to be respectful and supported people in a dignified manner.

We saw referrals to healthcare professionals had been made appropriately. For example when people had experienced falls, their GP and the falls team had been contacted for advice. When it had been identified that people had swallowing difficulties a speech and language therapist had been contacted. People's weight was monitored and when gains or losses had been identified referrals had been made to a dietician and documented in people's care records. Records had been maintained of visits made by healthcare professionals and any advice given had been incorporated into people's care plans.

Requires Improvement

Is the service caring?

Our findings

Regular staff knew people well and demonstrated an understanding of the preferences and personalities of the people they supported. However relatives raised concerns with us that other staff did not know their loved one's well and had little insight into their personalities and needs. A relative of one person who was living with dementia and could no longer articulate their needs told us their loved one was a sociable person who liked to be around people. However the relative also felt their loved one was becoming socially isolated because they were spending most of their time in their room rather than being supported to the communal areas where they could benefit from the company of others.

We observed most people who spent time in their rooms were positioned in a chair or in bed so they had their back to the door which meant they were not able to see people as they went by. There was no information in people's care plans to say that this was their preference. We brought this to the attention of the registered manager who told us people were not usually positioned in this way. On the next day of the inspection most people were positioned so they were facing the door and could see people as they went past their room however records did not show whether this was people's preference.

People's dignity was respected and promoted most of the time. However we also saw areas of practice that needed to improve. For example the relative of one person told us their loved one, who was in bed fully dressed, commented "The trousers they've got on aren't theirs and they are in bed with their slippers on". They also told us that their loved one's spectacles and teeth often went missing. On the first day of the inspection we saw the room of another person required repairs to be made to the walls in their room, the mattress protector was torn and the mattress was old and stained. When we brought this to the attention to a member of the senior management team the mattress was replaced with immediate effect and on the third day of the inspection we saw that repairs had been made to the walls. The registered manager also informed us that the room would be re-decorated to make the room more homely and inviting.

Staff told us about how they protected people's dignity for example by closing doors when they were delivering personal care. Our observations confirmed that doors were kept shut when personal care was being delivered and if people's doors were shut staff knocked and waited for a response before entering rooms.

The majority of people's care records were stored securely in locked offices however we saw some records which contained people's personal information had been left out on a table in a communal area of the service. When we highlighted this to the registered manager they moved the records immediately. However this is an area of practice that needs to improve and be sustained.

Staff communicated with people effectively and respectfully. We observed that staff communicated with people in a warm, friendly and sensitive manner that took account of their needs and understanding. Staff took care to maintain and promote people's well-being and happiness; for instance, one member of staff explained one person could get quite anxious. It was evident from our observations that this staff member knew this person well and had a good understanding of their communication needs. We observed them

supporting this person to eat at a pace to suit them and laughing and joking with them.

We observed staff treated people with kindness and understanding. Interactions and conversations between staff and people were positive. People and their relatives told us they felt regular staff were kind and we observed staff showing patience and understanding, for example by giving people who struggled to communicate verbally time to express what they wanted to say.

People were supported to maintain relationships with people that mattered to them. Visitors were welcomed into the service and could visit at any time.

There was information available to people on how to access advocacy services. The registered manager told us they had supported one person to obtain an advocate and records we saw confirmed this.

Each person had their own room which had been personalised with their belongings and memorabilia such as pictures of their friends and family. Some people had also brought items of their own furniture to make them feel more at home.

Requires Improvement

Is the service responsive?

Our findings

People were able to visit the service and have their needs had been assessed before they made a decision about whether the service could meet their needs. Two relatives confirmed they had come to have a look round the service, meet people and staff before their relative moved in. People's initial assessments had been used as a basis on which to formulate a care plan which detailed the support each person required to meet their emotional, social and personal care needs Our findings in relation to the quality and detail of the guidance in the care plans were mixed. Some care plans were very detailed and provided specific guidance for staff to follow when supporting people with their individual needs, for example they included step by step guidance for how to support a person to transfer from their bed to their wheelchair using a hoist. However not all care plans contained this amount of detail, some were out of date and some sections of some had not been completed at all. For example the social activity section of one person's care plan was blank and the mobility section stated they could walk with support but they could no longer walk at all.

The information above demonstrates a breach of Regulation 17 of the Health and Social Care Act Regulations 2014.

Despite the lack of up to date information in the care plans regular staff knew people well and had a good understanding of their care and support needs. They told us any changes to peoples care needs were passed on at staff hand over meetings at the beginning of each shift and at the mid-morning 'flash meeting'. They also told us there were always other staff and management on duty they could go to for advice or provide them with updates on their return from a leave of absence from work.

People's care plans detailed how people they preferred to spend their time and what their hobbies and interests had been before they moved into the service. Group activities were provided on a daily basis and there was a timetable on display to inform people of what was on offer. Staff told us each day they reminded people what the activity was and asked them if they would like to join in. On each day of our inspection we saw a small group of people were engaged in craft activities which they enjoyed. People also had the opportunity to have trips out in the provider's mini bus which staff told us was mainly used in the warmer months. Records also showed over recent month's people had also participated in activities such as exercise classes, attending lunch club, reminiscence sessions, going to the Christmas party, visiting the hairdresser, watching external entertainers and having a film day. In addition to this staff told us and records confirmed, they spent time with people on a one to one basis.

Despite the activities on offer some people's relative's felt their loved ones and did not always have enough to keep them occupied and stimulated throughout the day. Our observations were that although staff did spend some one to one time with people daily records provided little detail of how people had spent their time. For example one person's daily records showed that with the exception of visits from family the only social interaction or activity the person had been involved in since January was a one to one session with staff once a week.

There were systems in place to respond to complaints. People were provided with information about how to

make a complaint when they moved into the service and complaints received by the provider had been recorded and responded to appropriately. There was also a 'feedback station' which had an electronic touch-screen for visitors to comment on their visit to the service.

We looked at the systems in place to help support people at the end of their life. We saw that care files showed that end of life care had been discussed with people and their preferences had been recorded within their plans.

Requires Improvement

Is the service well-led?

Our findings

We looked at what systems were in place for the provider and registered manager to be able to monitor the quality and safety of the service provided at the service. Records showed audits which looked at a variety of areas, including staff training, supervisions, the appearance of the home, lunch time experience, accidents and incidents, infection control, medicine management, care planning and health and safety took place on a regular basis. When areas of improvement were identified through these checks actions had been taken to address them. For example, when we arrived at the service on the first day of the inspection, two members of the senior management team were at the service to review the care of people they had identified were experiencing a high number of falls.

Despite the systems in place, not all the provider's processes to assess monitor and improve the quality and safety of the services provided were effective and records required to be maintained were not always accurate and up to date. For example audits of people's MAR and care records had not identified that PRN and covert medication protocols lacked specific guidance for staff to follow or that people's medication care plans and MAR contained conflicting information and guidance. Mattress checks had failed to identify that the cover on one person's mattress was torn and checks on records relating to accidents and incidents had not always identified that the relevant external agencies had not been informed. Daily records for some people were minimal described the care interventions but contained no further details of how the person had spent their day. Therefore the provider was not able to monitor whether or not people were receiving all the care they needed.

The provider and registered manager had identified improvements were needed in relation to staff recruitment and retention, staffing levels and the management and deployment of agency staff. However their response to making these improvements had been slow which in turn meant the shortfalls had continued and negatively impacted on the safety and continuity of people's care.

The information above demonstrates a breach of Regulation 17 of the Health and Social Care Act Regulations 2014.

The registered manager had notified the Care Quality Commission (CQC) of most incidents that had occurred in the service in accordance with our statutory requirements. However there had been some incidents of potential abuse that had been reported to the local authority but not to CQC as required.

This is breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

During the inspection the provider and registered manager told us they had already identified some of the shortfalls we had identified at our inspection. For example they were working with their human resources department to look at ways of improving the recruitment and retention of staff. They were also exploring the possibility of sharing staff from the provider's other services in order to ensure sufficient numbers of suitably qualified staff were always on duty. In response to the concerns we identified the registered manager and provider implemented an action plan and started taking action to address the shortfalls we had identified

with immediate effect. Following our inspection the provider contacted us to inform us they had completed some of the actions including an audit of the medicines, moving the registered manager's office to the ground floor where they were more visible and could see who was in the building, updating some people's risk assessments and care plans and improving the deployment of staff. This action increased our confidence that they had taken the concerns we raised seriously.

The provider and registered manager worked well with health and social care professionals such as the falls team, occupational therapists and social workers in order to achieve the best outcome for people. However we did not see the provider had taken any action to meet the recommendations made by Healthwatch following their 'enter and view' visit in December 2017 to try to develop working links with community organisations to improve the range of activities on offer.

Management were approachable. We observed staff coming to the various offices to speak with management about a range of issues during the day and discuss people's care. The registered manager was supported by two deputy managers and an administration assistant. Some staff told us morale had been low over recent months but was improving. They told us they were hopeful the registered manager would bring about improvements to the service and the provider's recruitment drive would result in more staff being employed and less reliance on agency staff. One member of staff told us they had made some suggestions for improving the service which the provider had adopted. One of these was a walking handover with staff visiting and accounting for each person in turn. Staff told us they felt this worked well and the registered manager told us the provider was considering rolling this out to other services.

People had been asked their opinions of the quality of the services provided by way of a satisfaction survey. The registered manager showed us the results from the last survey in 2017 which showed a high level of satisfaction. There was also a schedule of meetings for staff, people who lived in the service and their relatives. These were advertised within the service so people were aware of them and we viewed the minutes of previous meetings. People and their relatives had the opportunity to share their views of the service at these meetings however the registered manager told us the meetings were not very well attended.

Ratings from the last inspection were displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

A range of policies and procedures were available to help guide staff in their role. Staff were aware of the policies and told us they referred to them when needed.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that CQC had always been informed of significant events that occurred at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people always received safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that appropriate action to safeguard the people from abuse had always been taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the processes in place to assess monitor and improve the quality and safety of the services provided were effective or that records were always accurate and up to date.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured there were sufficient numbers of suitably qualified and experienced staff on duty at all times.