Quality Care Homes Limited

Little Croft 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**

Summary of findings

Overall summary

Little Croft Care Home provides accommodation and personal care for up to 41 people. At the time of our visit there were 31 people living at the service.

At the previous inspection carried out 29 June 2017 and 4 July 2017 we rated the service as Requires Improvement and identified concerns around medicines, compliance with the Mental Capacity Act 2005 (MCA), recording of information and ineffective quality monitoring audits. The registered manager had submitted an action plan to the Care Quality Commission so that we could monitor the improvements made.

At our inspection on 3 and 4 July 2018 we found that the provider had made some improvements. However further improvements were still needed.

During this inspection, we found that the registered provider was in breach of multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. We rated the service overall Requires Improvement.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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.

Risks to people had not been assessed and the appropriate action had not been taken to reduce or eliminate risks to people.

People were at risk of harm as the appropriate checks of people's wellbeing had not been undertaken by staff to ensure people were safe at the service.

People's ability to consent to care and support had not been assessed in line with legislation and guidance.

We identified concerns where people lacked capacity. When applications had been submitted for assessment under the Deprivation of Liberty Safeguards the appropriate action had not been taken to ensure these people were safe.

People's care records were not always up to date or a reflection of their needs. There was a risk that people were not receiving the care and support that they needed.

Quality monitoring systems were not in place to identify, monitor, manage and mitigate risks. Audits undertaken were not effective and had not identified the shortfalls which we found at the service.

People told us they felt safe living at the service. Staff were aware of what constituted abuse and the actions they should take if they suspected abuse.

People were provided were cared for by adequate numbers of appropriately skilled. Staff recruitment procedures were safe and the employment files contained all the relevant information to help ensure only the appropriate people were employed to work at the service.

Medicines were handled appropriately and were now stored at the right temperature. Medicine Administration Records (MAR) were now appropriately signed to indicate people's prescribed medicine had been given. Clear protocols were in place for as required medicines.

Staff received appropriate training and support to ensure they had the knowledge and skills needed to perform their roles effectively.

People were supported to meet their dietary needs and preferences. They also received the support they needed to stay healthy and to access healthcare services.

People said they were treated in a kind and caring manner. People's privacy and dignity was respected.

People's wellbeing was supported by the activities. The service had a range of activities for people to take part in.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

The service had not taken the appropriate action to ensure people were safe which compromised people's safety. The service did not always assess the risks to people's health and safety during care or support.

There were sufficient staff to meet people's care needs. New staff were recruited safely.

Medicines were now safely managed.

Is the service effective?

Requires Improvement

The service was not effective.

The principles of Mental Capacity Act (2005) had not been adhered to. The appropriate assessments of people's capacity had not been undertaken. Where best interest decisions had been made they were not always recorded. The appropriate action was not always taken to keep people safe who lacked capacity.

Staff received sufficient training to enable them to effectively meet people's individual needs. Staff had regular supervision and support.

People were supported to eat and drink.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Requires Improvement

The service was not responsive.

Staff knew people well. However, people's care records were not a true reflection of people's needs. There was a risk that people were not receiving the care and support that they needed.

People enjoyed person centred care activities.

Positive comments were received from people about the care and support that they received.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems in place to monitor and improve the quality and safety of the service were not effective. Failings in the running of the service had not been identified prior to our inspection.

Systems were in place to gain feedback from people.

We received positive comments about the leadership of the service.

Little Croft 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 was 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.

We undertook a comprehensive inspection at Little Croft Care Home on 3 and 4 July 2018. Due to the concerns we found at the inspection on 29 June 2017 and 4 July 2017 we carried out a further full comprehensive inspection. Prior to this inspection concerns were raised with CQC about the service. We used the information as intelligence to help us plan this inspection. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not requested the provider to complete the Provider Information Record (PIR) before the inspection. This is a form that asks the provider to give information about the service, tells us what the service does well and the improvements they plan to make.

We contacted four health and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the service. We received a response back from two professionals. We spoke with nine people who lived at the service. We also spoke with the relatives of seven people. Some people were able to talk with us about the care they received. We sat and observed other people who were unable to communicate.

We spoke with six staff which included the registered manager, the deputy manager, admin staff and care

staff. We looked at the care records of five people living at the service, three staff personnel files, training records for all staff, staff duty rotas. We looked at other records in relation to safeguarding, complaints, mental capacity and deprivation of liberty, audits, accidents and incidents and equality and diversity.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 29 June 2017 and 4 July 2017 we found medicines were not always managed safely. We identified several gaps where staff had failed to sign confirming people had received their medicines as prescribed. Medicine administration records (MAR) had several transcribed entries, where staff had handwritten people's medicines. Some of these had been initialled by the staff member who wrote them, and none had been countersigned. Eye and eardrops had not been labelled with the date of opening, despite dispensing labels having clear instructions. The medicines room temperature was monitored. However, the temperature had been recorded as 25 degrees centigrade for 11 days during June. On another occasion the temperature had been recorded as 26 degrees. The appropriate action had not been taken to ensure medicines were stored at the correct temperature. Medicines that required refrigeration were stored in a medicines fridge. When checking the fridge temperature, we found the thermometer was reading 9.5 degrees centigrade on the day of our inspection. The recommended temperature for medicines fridges is between 2-8 degrees centigrade. Stocks of PRN (as required) were checked and we found PRN protocols were not in place.

At this inspection we found great improvement had been made in managing people's medicines. We were told by the registered manager that since the last inspection the deputy manager was overseeing the management of medicines. A different pharmacy was being used to dispense people's medicines. We checked through MAR charts and found they were appropriately signed by staff when medicines had been administered. We did not identify any gaps in people's records. At the time of our inspection we did not see any transcribed entries, where staff had handwritten people's medicines instructions onto MAR charts. The deputy manager told us they avoided writing on people's MAR charts. However, if at any time medicines were administered outside of the pharmacy opening hours clear protocols were in place. A second member of staff would check the entry, quantity and dosage and this would be double signed. Medicines were being appropriately stored at the right temperature. We checked the medicines room and fridge temperature recorded for the day of the inspection and the four weeks prior. This showed that temperatures were being taken and recorded four times each day and were within range. The appropriate action was taken when the room temperature had exceeded 25 degrees. An example being on 2 July 2018 the temperature taken at 7am was 23.9 degrees. At 6pm on 2 July 2018 the temperature had reached 26 degrees. The deputy manager had taken prompt action to move the medicines to an alternative storage area which was cooler.

We checked medicines prescribed to people as PRN (as required) and found that the clear protocols were now in place. An example was that one person was prescribed co-codomol and inhalers. Clear instructions were in place for the reasons when these should be given. Count down sheets were also in place with the current number of stock for each PRN medicine. Eye, eardrops and creams were clearly labelled with the date of opening recorded and the planned expiry date of each medicine.

Staff had a good awareness of people's needs and how to keep people safe. However, there had been an incident where the service had not taken the appropriate action to ensure people were safe which compromised people's safety by putting them at risk.

On the 31 May 2018 two people who suffered from confusion had left the service through a fire exit door without the staff knowing. Both people had travelled a considerable distance away from the service. It is not known how they managed to get to their destination as they left without any money. The registered manager told us the police had contacted one of the three senior night staff at the service by phone around 2.15am. This was to find out if the service were missing two people. The registered manager told us the police brought them back to the service and an ambulance was called to check they were both alright.

We reviewed records and found that one of the people had their medicines at 22.00 hrs the previous evening. After this time no, further checks had been carried out by staff to see if the two people were safe and in the building. This was the second time that one of the two people had left the building. On 5 December 2017 one person had left the service through a window and were brought back to the service shortly after by a member of the public. Although the registered manager had investigated this and made a safeguarding referral to the local authority the appropriate action to prevent a reoccurrence had not been taken. We looked at the two people's records and found that risk assessments had not been put into place. This would have assessed the risks to them and identified steps that should have been taken to minimise further risk.

Some people who lived at Little Croft Care Home lived with a dementia type illness and lacked capacity with regards to their safety when leaving the building. We looked at the fire door that both people had exited the service through. This was located at the side of building downstairs. The fire door had a door release button and two bars which could be pushed down to exit. This led around to the front of the building which meant the area was not secure. Gates and fencing were set back behind the fire door rather than in front. Two professionals had also given us feedback and voiced their concerns to us. Both professionals felt the appropriate action had not been taken to ensure people were safe. We discussed our concerns with the registered manager and they told us they would speak to the provider to get the gate and fence moved forward. We were told in the event of a fire the garden gate automatically released. This meant the service did not always assess the risks to people's health and safety during any care or treatment.

The above amounted to breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the service. People told us, "I feel safe here, never had any problems" and "Yes I feel safe, its lovely here". Another person told us, "I don't even think about being safe as I have no reason not to be" and "I absolutely feel safe living here". One relative told us, "My mum is safe here and all my worries are gone since she lived here".

Staff told us they had received safeguarding training to protect people from avoidable harm and abuse. Through scenario based questions they demonstrated they knew what to observe for and how to report concerns. One member of staff told us, "If I saw bruises, I'd report it straight away". Staff also said they felt confident to raise concerns about poor care. Comments included, "If I had concerns about anything at all, I would report it" and "If I saw something or was worried about poor practice I would report it. I would report anonymously to CQC if I didn't think it had been dealt with". One professional had commented that they had no specific safeguarding concerns.

There were suitable systems to protect people from the risk of cross infection. Records showed that the registered manager had assessed, reviewed and monitored that good standards of hygiene were maintained in the service. We found the service was clean and had a fresh atmosphere. However, we found that two downstairs toilet bins had foot pedals that did not work. This meant that the staff had to open the lid on the top of the bin. We spoke to the registered manager about this who advised us they would replace

the bins. One downstairs hallway carpet was heavily stained however plans were already in place to replace this as carpet washing had not been effective.

Comprehensive health and safety checks and maintenance of the building and equipment were undertaken. Health and safety checks of the premises had been completed to ensure it was well maintained and any risks to people's health and safety were identified and addressed. Fire drills had been carried out, testing of the fire alarm and equipment were completed by staff.

Staff we spoke with said they believed there were enough of them on duty to meet people's needs. Comments included, "We've got enough and we've got new staff starting soon too" and "There's always enough staff. If someone calls in sick the registered manager will come in and help if we need her too". One member of staff added, "Of course it would be lovely to have more of us on duty. I think if we had more we could spend more time with people".

Appropriate arrangements were in place to ensure that the right staff were employed at the service. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining a full employment history, gaining written references, ensuring that the applicant provided proof of their identity, undertaking a criminal record check with the Disclosure and Barring Service (DBS) and conducting pre-employment interviews.

Requires Improvement

Is the service effective?

Our findings

At the last inspection 29 June 2017 and 4 July 2017, we identified improvements were required to ensure people's mental capacity had been assessed. In some people's care records there was nothing to show how a decision had been reached or whether it was the least restrictive option or in the best interest of the person. At this inspection we found that further improvements were required.

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.

Consent to care was not always sought in line with legislation and guidance. Although we saw that some people's capacity to consent to aspects of their care had been assessed, this was not seen consistently. For example, one person had a door alarm in place to alert staff if they left their bedroom during the night. The person was at risk of falling and the alarm was in place to help staff keep the person safe. The person's capacity to consent to this restriction had been assessed. Because they lacked the mental capacity a best interest decision had been made. There was a record of how the decision was reached and who had been involved in it in line with legislation. Another person had bed rails in place. However, the person's ability to consent to these had not been assessed through a capacity assessment and there was no evidence of a best interest decision meeting taking place. This meant that consent was not always sought from people in line with the Mental Capacity Act 2005.

The above amounted to breaches of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection two people's application had been authorised by the local authority. Records showed eight further application forms for people were awaiting assessment by the local authority or were awaiting a decision to be made. These were submitted as some people could not freely leave the service on their own, also because people required 24 hour supervision and support from staff. The DoLS provide a legal framework and allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

We discussed with the registered manager the concerns we had that two people who were assessed to have lacked capacity were able to leave the service. Two professionals had given us feedback and expressed their concern over the incidents. On the 10 April 2017 a DoLS application was submitted for one of the people. On the 2 February 2018 a DoLS application was submitted for the other person. This was because both people lacked the capacity to leave the building freely on their own and required 24-hour supervision. It would be seen as unsafe for them to do so. On submitting a DoLS application to the local authority this would have

given the service authorisation to restrict a person's liberty urgently until they were assessed by a professional. On the first occasion one person had left the service through a window. On a second occasion two people had left the service through a fire door. The registered manager told us they could not guarantee 100% that they could keep people inside the service as they were not a secure unit. However, the service had a key pad on the front door to enter and exit the premises. The registered manager told us they had received DoLS training. We discussed our concerns with the registered manager around their lack of understanding of DoLS and keeping people safe. Even though both people had not had their DoLs authorised at the time, the service had already identified both people lacked capacity. The registered manager failed to contact the Local Authority DoLS team after the incident to make them aware of what had happened. This meant that people who lacked capacity were not safe from the risk of harm.

The above amounted to breaches of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we identified concerns that people's capacity was not always assessed the staff demonstrated a good understanding of the principles of the Mental Capacity Act. One staff member told us, "People have a choice and a right to make their own decisions" and "Sometimes we do things in people's best interests, but when you know residents really well, you can usually work with them." They explained how they ensured people who refused personal care were supported to keep clean. This was done in a sensitive way which was also respectful of the person they were supporting.

Staff told us they felt they had the appropriate training to carry out their roles. One staff member told us, "I had a thorough induction. I've done lots of training since starting". Another staff member told us, "I've had lots of training. If we need more, we can just ask".

Staff told us they had regular supervision and an annual appraisal. All said they felt supported in their roles. Comments included, "I feel well supported" and "All of the staff support me. The registered manager is a great support. I can go to her with anything".

People's nutritional needs were assessed. People's preferences for what they liked to eat and drink were documented. For example, in one person's care plan it was recorded "Likes smaller meals" and "Needs food cut up." People's weights were monitored. When needed, support and advice was sought. For example, we saw that one person had previously lost weight and staff had asked the GP to review them. The person was then prescribed food supplements to have alongside their meals. We found shortfalls in the recording of food and fluid charts. Therefore, we could not be certain that people had sufficient amounts to eat and drink.

We observed lunch in one of the dining areas. Several people were sat at tables where flowers and menus were on show. There was a sociable atmosphere as people were talking with each other whilst they waited for lunch to be served. People were offered drinks and a choice of main meal. Staff asked if people were enjoying their meals and if they wanted more. When one person asked for ice cream a member of staff brought this. When the person then said they didn't like the flavour of it, the member of staff immediately offered to bring a different flavour to them. One person told us, "The food was good, with lots of choice". We observed one person was being assisted to eat their meal. We over heard there was laughter and good conversation between the person and the member of staff. The same member of staff also noticed a person had not eaten their meal and was offered a different choice.

People had access to ongoing health care. The deputy manager told us, "We have a good relationship with the GP. They call every week and if needed they will come and review people". Records showed people were

reviewed by the GP and the district nurse.

Training was completed on a rolling programme available for all staff. Training completed included DoLS and MCA training, safeguarding adults, basic first aid, health and safety, moving and handling, fire, infection control and food safety. Other training included pressure wound care, palliative care, continence and medicines.

Good

Is the service caring?

Our findings

There was a friendly and relaxed atmosphere. People appeared relaxed around staff and we saw and heard staff talking and laughing with people. Staff told us they enjoyed their job. One person told us, "I've stayed here because of the residents. The care here is good. If I'm on a day off, I'm still thinking about the residents". Another person told us, "Of course, the care is good here. The staff are loving and really do care about the people living here. We know people really well so there's great continuity". One relative told us, "The care is good, they help them along. The staff are friendly and the older ones seem more experienced".

Throughout our visit the atmosphere in the communal areas was good natured and people looked relaxed and happy in the company of the staff who, when needed, provided comfort and reassurance to people. For example, holding their hands. Staff spoke fondly about the people they supported and it was clear they had developed a good relationship with each person and their families.

Staff knew how to respect people's privacy and dignity. One person told us, "I always whisper to people if I think they need some help with personal care" and "I always close the door and the curtains. I knock on people's bedroom doors before going in, even if they can't answer, I would always knock first".

People were treated with compassion and respect. We observed staff talk positively about the people they supported, showing respect for their feelings and acting on their wishes. There was a relaxed atmosphere and people were confident to approach staff. Any requests for support were responded to quickly and appropriately. We observed people using the space around the service independently. This included the lounge, garden and their bedroom. Staff offered encouragement and support and allowed people to go at their own pace.

Some people who used the service were unable to tell us about the care they received, but throughout our visit staff addressed people in a respectful and considerate manner and communicated with people as individuals. For example, by giving people time to respond to questions and keeping sentences short. There were good interactions between staff and people who used the service, particularly those living with dementia.

We observed that staff were attentive towards people's needs. One staff member had noticed a person in the lounge appeared to be agitated. They asked the person how they were feeling. The person told the staff member they felt giddy and wanted to go to bed. The person told the staff member they felt a nuisance. The staff member responded in a gentle manner reassuring them that they weren't. They offered to get the person a sweet cup of tea (their favourite drink) and to then see if they still wanted to go to bed after.

People told us they liked their rooms and they were comfortable warm and clean. People's rooms were personalised with ornaments, pictures, soft furnishings and photographs. Some people also had pieces of furniture which they said they had brought in from their previous home.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection 29 June 2017 and 4 July 2017, we identified improvements were required. This was to ensure guidance was in place for those people who took medicines or were insulin controlled diabetics. At this inspection we found improvement had been made and guidance was now in place for the staff. This was to recognise the signs and symptoms of 'hypo' or hyperglycaemia. The registered manager told us they had reviewed people's care records to ensure where someone had a medical diagnosis there was guidance in place. However, at this inspection we found further improvements were needed.

People's care plans we looked at were not always up to date or a reflection of their needs. An 'acute care plan' was in place for one person at the front of their main care plan but this had not been dated to indicate it was the most up to date version for staff to follow. Additionally, the guidance for staff was limited. For example, staff had written, "Stays in bed for comfort" and "Turn two hourly", and "Needs assistance with all meals". The person had a catheter in place but there was no information for staff on how to care for this. The main care plan contradicted what had been written in the acute one. For example, the old plan referred to the person being mobile and independent, but this was no longer the case. The registered manager told us the 'old' plan was no longer in use, but this was found amongst other care plans.

Another example was that one person's care plan recorded the person lacked capacity and was reluctant with being assisted with personal care. We checked the person's care plan which stated the person was only independent to wash their hands and face. The person also had continence needs. We checked the person's daily notes which showed the person was being given inconsistent care by staff. Some staff recorded personal care given and pad changes. Other staff had recorded, "Independent", "Did herself", "Arrived refused personal care to try again later". The daily notes did not record that staff had tried later and helped them with personal care. It was clear from reading this person's daily notes that the person required a higher-level of care and observation to manage their care needs. This meant there was a risk that the person was not receiving the care and support that they needed.

End of Life plans were in place, but of the two we looked at neither had been completed in full and did not provide staff with information on people's choices about their end of life care. Staff had written within one person's care plan, "Would like to leave with family." This was dated May 2018, but it wasn't clear if this meant the plan should be left for the family to write in. In one person's plan there was a do not resuscitate order in place. However, when we looked at the person's end of life plan staff had documented that the person wanted to be resuscitated. This meant there was a risk staff would not know what action to take in the event of an emergency.

The above all amounted to repeated breaches of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other plans we looked at had been reviewed monthly. Although none of the plans we looked at had evidence of people's relatives being involved in reviews, the deputy manager said families were invited to participate in these.

Despite the concerns we found with people's care records, staff we spoke with were familiar with people's needs and through discussion, demonstrated they knew the support people required. One staff member said, "We get a good handover, plus I read the care plans. We get to know people over time by having conversations with them, learning about them and their interests".

One-page profiles were in place as well as documents titled 'My support plan'. These were very detailed and provided lots of information for staff on what was important to people and how they wanted staff to support them.

Staff told us how resident meetings kept people informed about any changes within the service. This included discussions around menus, activities and outings. Minutes of the meetings confirmed information was recorded and discussed and included actions from previous meetings.

Two activity co-ordinators worked at the service. During the inspection we observed one person having their nails done and appeared engaged in conversation with the staff member. The same person participated in meaningful activities by helping to serve people their meal at lunchtime. We observed another person folding laundry which they enjoyed doing this. The staff told us the person liked to peg out the washing and sometimes wash up after lunch. Another person was doing some colouring, the person told us this was there hobby. There were number of examples of the work they had completed previously. We observed positive interactions when a visitor brought their dog into visit. It was clear people enjoyed having the dog visit them.

The service had a two-week activity timetable. Activity's included knitting, gardening, movie afternoon, group chats, dog visit, skittles and a choice of outing's. A planned trip to Longleat was cancelled the week before our inspection due to the hot weather. This was being rescheduled for September. A Vicar visited the service every Friday and a hairdresser twice weekly. One relative told us, "My mum joins in with activities but needs to be asked, I think the activities are good".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 29 June 2017 and 4 July 2017 we found some improvements were required to ensure the service was well led. This was because the checks that were being carried out on the quality of the service and delivery were not always effective. We found there were shortfalls in some areas such as medicine management and the recording of care delivery such as personal care and care planning. At this inspection we found further improvements were needed.

Improvements were required with the quality of record keeping. We could not be satisfied that people were receiving a nutritious balanced diet or adequate hydration. This was because some records relating to food and fluid charts were not consistently completed. Some people who were at risk of malnutrition or dehydration were having their food and fluid intake monitored. The quality of information recorded on food charts was poor. On some charts we looked at there were significant gaps where it appeared people hadn't eaten for some time. One person's chart recorded that on one day they had eaten breakfast and then had nothing except some biscuits during the night. On another occasion, the chart indicated the same person had eaten nothing all day until teatime when they had soup and yoghurt. Another person's chart also indicated they had gone long periods with nothing to eat on several days. On another day staff had recorded the person had eaten sandwiches and cake at teatime but nothing else. However, the daily notes for the same person stated they had eaten lunch.

Fluid monitoring charts were also of poor quality. Although daily targets were listed on the charts, the actual target for individual people had not been highlighted. One person's daily target was 1446 millilitres per day, but the fluid charts did not indicate they had received this. One chart, which was not dated, indicated the person had only 225 millilitres all day. On another day the recorded intake was only 400 millilitres. The daily records for this person made no reference to how much the person had drunk each day.

We checked people's daily notes and found they did not reflect the information on the monitoring charts. Staff told us the charts were checked daily, but records we looked at did not show the charts had been monitored. One member of staff told us, "We know we need to improve on the charts".

People's daily notes were not comprehensive in recording information about people's wellbeing. An example being was the written recording within two people's daily records. This related to an incident on 31 May 2018 where two people had left the service without the staff knowing. We identified gaps with the recording of both people's notes. Within the daily notes of one person the last recording of their wellbeing on 31 May 2018 was at 11am. No further entries had been made by staff about the person missing until 1 June 2018 at 19:00hrs where staff had recorded that they received a call from the police. This was to alert them a person had been found believed to live at the service. The other person's last recording on their daily records was on 31 May 2018 was at 10.00hrs. The next entry after this was on 1 June 2018 with the same information recorded. The information recorded had been entered retrospectively and contemptuous notes about the incident had not been written. This should have included the time that the police phoned the staff, the time the ambulance arrived and information about monitoring both people's wellbeing.

This meant that people's records were not appropriately completed by staff to help them monitor people's wellbeing. Care documentation was not always a true account of people's wellbeing and were not completed accurately.

Other shortfalls with regulations had not been recognised or addressed. This included concerns in relation to keeping people safe and assessing the risks to people, shortfalls within people's care records and the principles of the mental capacity act not being followed. Our inspection identified that this service had not been consistently well led. This meant that the leadership from the registered manager and provider was not driving forward improvements.

The above amounted to a repeated breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager. A registered manager is a person who has registered with the 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 2008 and associated Regulations about how the service is run.

Despite the concerns we found at the inspection all of the staff we spoke with told us the service had made improvements since our last inspection. They told us, "The management is much more hands on now, more visible. Our documentation is a bit more organised too" and "The deputy has made quite a lot of changes. He chases people up to make sure things are done properly". The deputy manager told us, "It's a work in progress. It takes time, but I do believe we are moving in the right direction. Teamwork, communication and medicines have all improved. I'm working with the seniors to start on the care plans next".

Staff told us morale was "good". One comment included, "The deputy manager is good. He's making changes for the good, but he's taking the staff along with him, encouraging them" and "There's much better teamwork now". Staff spoke highly of the registered manager. Comments included, "The registered manager is so understanding, you can go to her with anything and she'll help" and "The registered manager is very approachable. I think she's a good manager".

Resident and relative questionnaires were completed. We were shown copies of questions that people and relatives had completed. All the feedback was positive and the results were due to be analysed by the registered manager.

Although the registered manager was aware when notifications of events had to be sent in to CQC there had been two occasions when this has not been done. A notification is information about important events that have happened in the service and which the service is required by law to tell us about. On 5 December 2017 and 31 May 2018 two incidents occurred at the service which compromised people's safety. Both incidents were reportable to the CQC. The registered manager had failed to submit a notification of safeguarding to the CQC.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating at the service and on their website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care place was not a true reflection of people's needs. We identified gaps with the assessment of people's needs (9) (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from people in line with the Mental Capacity Act 2005. (11) (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always assess the risks to people's health and safety during care or treatment. Risk assessments were not always in place to manage the risks to people. 12 (2) (a), (b), (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who lacked capacity were not always protected against the risks of harm. 13 (1) (2).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

Audits were not effective and had not identified the shortfalls we found at the inspection. The leadership from the registered manager and provider was not driving forward improvements. (17) (1) (2) (a) (c)