

# Platinum Home Care (South Coast) Limited Auburn Lodge Residential 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

This was an unannounced inspection which took place on 5 June 2017. We also went back to the home on 12 June 2017. Notice of the second day of inspection was given as we needed to make sure members of the management team would be present in order that we could explore further some of the evidence we obtained on the first day of inspection.

Auburn Lodge Residential Home is a care home for up to nine older people. If people require nursing care district nurses attend to them at the home. The home is located in the sea side town of Selsey, West Sussex. It provides both permanent and respite placements. At the time of our inspection nine people lived at the home. This included one person who was staying for respite. People's needs varied. Some people were quite independent and only needed minimal assistance whilst others required assistance with all aspects of their care.

During our inspection the registered manager (who is also the provider) was on leave. 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. In the registered managers absence support to the home was provided by an assistant manager, a trainee manager and a senior care supervisor.

This was the first inspection of the home since it registered with CQC in June 2015. Although generally people told us that they were satisfied with the service provided we found that the registered manager had not ensured the quality and safety of the service was monitored or that action was taken to improve service delivery. Quality assurance systems did not cover all aspects of the service and as a result did not identify the shortfalls we found at the inspection. Assessment and care planning was not robust and did not ensure that people's needs were managed effectively and responsively. Risks to people's safety and welfare were not always assessed and action was not always taken to mitigate potential risks. When people sustained injuries that required treatment at hospital the registered manager had not notified us of these in line with her legal responsibilities. Although staff sought peoples consent when delivering care formal consent processes were not being used. The home was not following the requirements of the Mental Capacity Act 2005. You can see what action we told the provider to take at the back of the full version of the report.

Despite the above issues, people who lived at the home said that staff were kind and caring and as a result positive relationships had been formed that enhanced their sense of wellbeing. People said that they were treated with respect and dignity. We observed interactions by staff that were genuine, warm, positive, respectful and friendly and people told us this was the norm. People said that the registered manager was approachable and sought their views, listened and acted upon them.

Staffing levels were sufficient to provide safe care. However people commented that they would like more opportunities for staff to spend time talking with them and socialising. Robust recruitment checks were

completed to ensure staff were safe to support people.

People said that in the main they were happy with the choice of activities on offer and that they were supported to maintain links with people who were important to them.

Staff were suitably trained and skilled and received training relevant to the needs of people who lived at the home. Staff were supported and received group and one to one supervision. Staff said that the registered manager was a good role model.

People said that they were happy with the medical care and attention they received. People were supported to access health professionals that included GP's, district nurses, chiropodists and opticians.

People said that the food at the home was good and that their dietary needs were met. There were a variety of choices available to people at all mealtimes. Home cooked meals and cakes were provided by a chef who based the menu on people's preferences.

Equipment was available in sufficient quantities and used where needed to ensure that people were moved safely and staff practiced safe moving and handling techniques.

Information of what to do in the event of needing to make a complaint was displayed in the home. During our visit we observed staff assessing if people were happy as part of everyday routines that were taking place.

## 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 consistently safe.

Risks to people's safety were not always assessed and managed well and this had the potential to place people at risk of unsafe care or treatment.

People told us they felt safe. Safeguarding procedures were in place that offered protection to people.

Medicines were managed safely.

There were enough staff on duty to support people and to meet their needs. However, people said they would like more time from staff to socialise.

Staff underwent robust recruitment checks to make sure that they were safe to support people before they started work.

### Is the service effective?

**Requires Improvement** 

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 were not always followed to ensure people's rights were upheld.

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life.

People were supported to eat a choice of meals that promoted good health.

People told us that they were happy with the medical care and attention they received. People's health and care needs were managed effectively.

### Is the service caring?

**Good** 

The service was caring.

People were treated with kindness and compassion by staff. Caring relationships had been developed that promoted

people's sense of wellbeing.

People were treated with dignity and respect. Staff were able to explain how they promoted people's dignity and privacy.

### Is the service responsive?

The service was not consistently responsive.

People's needs were not always assessed or planned in response to their individual needs and preferences. People were supported to express their views but were not always involved in making decisions about their care and support.

An activity programme was in place and people generally expressed satisfaction with the range of activities available.

People felt able to raise concerns and were aware of the complaints procedure. Systems were in place that supported people to raise concerns and their views and opinions were acted upon.

**Requires Improvement** ●

### Is the service well-led?

The service was not consistently well-led.

Robust systems were not being used to monitor and audit all aspects of the service and the quality of service people received.

Appropriate notifications about key events were not made to CQC in order for CQC to monitor and ensure that appropriate actions were taken to keep people safe.

People spoke highly of the registered manager and said that the home was well-led. Staff felt well supported and were clear about their roles and responsibilities.

**Requires Improvement** ●

# Auburn Lodge Residential 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 was an unannounced inspection which took place on 5 June 2017. We also went back to the home on 12 June 2017. Notice of the second day of inspection was given as we needed to make sure members of the management team would be present. The inspection team consisted of one inspector 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We checked information that we held about the home and the service provider. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with six people who lived at the home and two visiting relatives. We spoke with an assistant manager, a trainee manager, a senior care supervisor, four care staff and the chef.

We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included three

people's care and medicine records. We also looked at staff training, support and employment records, audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports.

This was the first inspection of Auburn Lodge Residential Home since it registered with CQC on 9 June 2015.

# Is the service safe?

## Our findings

Risks to people were not always identified and mitigated to ensure people's safety. Risks to people's safety were not always managed in line with the provider's policy. This stated that in relation to falls prevention risk assessments would be completed for all people on admission, falls prevention advice would be obtained from care professionals and prevention strategies implemented. Accidents and incidents were looked at on an individual basis and action taken if people sustained an injury for example as a result of a fall. However, preventative measures were not always explored to ensure risks were minimised. One person had fallen six times during 2017. Each time staff checked them and when necessary sought medical advice and attention. Records stated that a referral to the falls prevention team would be made by the GP. This had not taken place or been followed up by staff at the home. There were no records and none of the management team present during the inspection were aware of any audits of falls having been undertaken that would help to identify trends or themes.

One person's records stated that they chose not to use footplates on their wheelchair and that they understood the risks. However, no documented risk assessment, evidence of discussion or review of this was in place.

Another person had no documented risk assessments for any aspect of their care. This person had moving and handling needs and used a wheelchair. During May 2017 they sustained an injury whilst moving from one part of the home to another. Staff provided first aid however this had not resulted in a risk assessment being completed.

Another person went out into the local community by themselves to purchase personal items. There was no risk assessment in place regarding this and staff were not aware of any measures in place that would alert them if the person needed their assistance whilst doing this.

One person's dietary records stated they were to have 'soft food diet' however we observed that they were served a pureed meal. Neither staff or the chef could confirm which should be given and there were no records to confirm which was the appropriate meal consistency for the person. A Speech and Language Therapist (SALT) had previously been involved with this person's care however, it was unclear from records what the SALT had recommended.

An area of the driveway leading to the home was uneven and posed a trip hazard to people. This had been filled with stones in an effort to make the ground more even however it still posed a risk of tripping or falling. There was no signage in place to warn people of the potential hazard despite the provider's environmental risk assessment stating this would be put in place for any potential trips, slips or falls.

The registered manager did not consistently assess risks relating to the health and safety of people and did not do all that was reasonably practicable to mitigate those risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Medicines management was safe and followed guidance from the Royal Pharmaceutical Society. A member of staff responsible for giving people their medicines was able to explain in detail how they supported people to have their medicines safely and we saw this was applied in their practice. The member of staff did not sign Medicines Administration Record (MAR) charts until medicines had been taken by the person. Information about PRN (as and when required) medicines that included pain relief medicines was recorded on MAR charts. The staff member checked to see if people were in pain and wanted medicine for this. There were no gaps in the signatures of medicines administered on the MAR charts we sampled. Information concerning people's allergies, if they had them, were clearly shown on the MAR charts. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Training was provided in medicines management and this included a process of checking staff competency to administer medicines.

Medicine assessments and care plans were not in place for any of the three people whose records we examined. This was not in line with the provider's medicine policy and procedure. This is reported on further in the responsive and well led sections of this report.

People's views on staffing levels varied. One person said, "Sometimes during holidays and sickness they are short staffed and we have to wait but we are not neglected in any way." A second person said, "I think they are well trained but there's not enough and sometimes we have to wait quite a long time for help with personal care but when they come they're good. They help me choose what I want to wear and my washing and ironing is always done. If I've one grumble it's that there's not enough staff. I would like people to chat to and they're all so busy." A third person said, "I'd give them top marks. They're always there if I need help they keep my room nice and tidy and do anything I need doing and although it's the normal chores they do it with a good heart." A fourth person said, "I like it here, they're all on a very good level but they don't have time to sit and chat." Some of the people who made these comments moved into the home when it first opened and less people lived there and this influenced their views on time staff had to spend with them.

Staffing levels consisted of three care staff in the morning, two in the afternoon and during the night. A formal assessment tool was not used to decide safe staffing levels to determine how many staff were needed to meet people's needs safely. However, we saw that on the day of our inspection there were sufficient care staff on duty to meet the care needs of people. We observed that staff were available when people needed assistance with personal care.

Staff said that they had sufficient time to care for people safely. One member of staff said, "I would say we have enough time. We have more time to spend with people in the morning than afternoons but X (member of the management team) is flexible and puts on more staff if needed."

Safe recruitment processes were followed to help ensure staff were safe to support people. Staff recruitment records contained information that demonstrated that the provider took the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included written references from previous employers and evidence of a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. They also included application forms, at least two forms of identification and information about training they had received. A recently appointed member of staff confirmed that checks on their suitability had been obtained prior to them commencing work at the home.

People said that they felt safe from abuse. One person said, "The staff are very pleasant, never rude or nasty. There's more residents now so sometimes you have to wait your turn but yes I feel safe with them. They help me a lot. I had become almost unable to walk but they have been helping me since I came back from

hospital and yesterday I walked with my frame to the end of the corridor." A second person said, "I've never had any worries about being here. I do feel safe; I try to be as independent as possible. I think I'd have a job to find anywhere better."

The training matrix stated six of the 12 staff employed had received safeguarding training. Plans were in place for the remaining six staff to undertake this training by September 2017. Staff we spoke were able to explain the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. For example one member of staff said, "If it was a colleague abusing I would speak to my supervisor or the manager. If it was the manager I would contact CQC or social services. Also if I felt nothing was done I would take it further. By reporting hopefully the abuse would stop." A second member of staff said, "I would go to either X or X (members of the management team). If it was one of them abusing people I would look at the whistleblowing policy and also come to CQC. Abuse can be verbally shouting, physically rough handling, not using correct equipment, financial." One member of staff did not demonstrate sufficient understanding of the correct safeguarding procedures that should be followed and we fed this back to the management team during our inspection.

Checks on the environment had been completed to ensure it was safe for people. Equipment that could be used to assist people to move such as stand aids and the chair lift had been serviced with certificates of safety issued. Staff were able to describe safe moving and handling techniques and we observed these in practice. The provider had a business continuity plan in place to ensure that people's care would not be interrupted in the event of an emergency, such as loss of utilities or severe weather. Personal Emergency Evacuation Plans (PEEPS) were also in place for each person that would help ensure they left the home safely in the event of a fire. We did note that PEEP's did not specify the numbers of staff people would need to assist them. This is an area for development.

## Is the service effective?

### Our findings

The registered manager had not ensured compliance with the requirements of the Mental Capacity Act 2005 (MCA). 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).

People's legal rights to consent were not always upheld. Staff told us that one person who lived at the home did not have capacity to consent to aspects of their care or to living at the home. Mental capacity assessments had not been completed when necessary to establish whether a referral for DoLS authorisation was appropriate. In addition, mental capacity assessments had not been completed when changes in the person's ability to consent had occurred. This same person had medicines administered covertly. This means without their consent or knowledge. Records confirmed this had been discussed with their GP and was taking place in the person's best interests. However a mental capacity assessment had not been completed or DoLS application made despite the provider's policy stating in these instances this should take place. Staff informed us that a relative of the person had Lasting Power of Attorney (LPA) and was involved in making decisions about the person's health and welfare due to them lacking capacity to make decisions for themselves. Records were in place that confirmed the relative had LPA to make financial matters and this did not include LPA for health and welfare. LPAs are issued by the Office of the Public Guardian to ensure people have the legal right to act on behalf of individuals.

Another person was on restricted fluid intake. This was on the recommendation of a health professional. There was no evidence that this had been discussed with the person and their consent obtained.

People had bedrail risk assessments in place that considered alternative ways of keeping people safe. The assessments did not always include evidence that people consented to this equipment. For example, one person's assessment did not include evidence of discussion or agreement.

The provider's consent policy stated that if a person's capacity was in doubt contact would be made with an appropriate person to carry out an assessment. The policy went on to describe authorising authorities as the body who would carry out assessments. This is not in line with the MCA Code of Practice as assessments relating to day to day decisions should be made by staff directly involved with the person's care. Members of the management team and staff were not aware of their responsibilities to ensure mental capacity assessments were completed that were decision specific for people where their capacity to consent was in question. For example, one member of staff said, "If someone was unable to agree to live here I would speak to the family and speak to the GP to get them to do an assessment and for them to carry out MCA test."

The failure to consider people's capacity appropriately and to act in accordance with the requirements of

the MCA was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of formal assessment we observed that staff checked with people that they were happy with support being provided on a regular basis and attempted to gain their consent. Staff sought people's agreement before supporting them and then waiting for a response before acting on their wishes. For example, when giving people their medicines a member of staff explained what these were and checked they were happy to take before giving them. One person did comment, "Sometimes I feel they just do what they feel is right without asking me, I suppose they're just getting on with the job."

The training matrix detailed 12 staff. Of these, four had completed MCA training and dates were arranged for the remaining staff to undertake this in August 2017. Staff had appropriate understanding of people's rights to consent to care. One member of staff said, "You have to gain their consent for example before helping to wash. It can be verbally, using flash cards or a nod of a head. If someone says no, I make sure they understand and record in notes. I go back later to check they haven't changed their mind. I would explain it's for their wellbeing and to safeguard them. If continue to say no I would speak to X (registered manager).

Staff said that they received sufficient support in order to fulfil their roles and responsibilities. One member of staff said, "I get supervision. Actually I have got my next one on Wednesday." They told us they had received regular formal and informal one to one supervision and at the start of their employment they received an induction. Records confirmed staff received an induction that followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care.

Staff also said that they received sufficient training in order to care and support people. Training provided included moving and handling, first aid, fire safety, food hygiene and health and safety. A programme was in place that included courses that were relevant to the needs of people which included dementia care and equality and diversity.

People were very complimentary about the food at the home and the chef. One person said, "The food is good and the chef is great. He will do something different for you if you ask. There's plenty to eat and you can even have a cooked breakfast if you want it."

We observed the lunchtime experience. Staff offered assistance to people when needed. Some people choose to have their lunch in the dining area and others in their rooms. Five people choose to have their lunch in the dining area. The staff served them the meal and then withdrew from the dining room. The meal served at lunchtime looked appetising and we noted that everyone in the dining area ate all of their meal. Wine was offered to people with their lunch. Throughout the day staff regularly popped in and out of people's rooms offering tea, coffee or cold drinks.

Homemade cakes were offered to people with their afternoon tea and it was apparent that these were greatly enjoyed. A menu was in place that offered a variety of freshly prepared meals and desserts. The chef checked with people each day what they would like to eat and was observed offering alternatives to choices on the menu if people did not want what was advertised. We did note that information was not available in the kitchen about people's dietary requirements however; the chef was able to tell us about this without referring to records. This included people who required fortified meals, pureed foods and peoples likes and dislikes.

People were happy with the support they received to manage their healthcare needs. One person said,

"They arrange the doctor's appointments for me." People were supported to access healthcare services and to maintain good health. This included calling a GP promptly as required and also having access to district nurses, chiropodists and opticians. The advice and guidance given by these professionals was followed.

Bedrooms were located on the ground and first floor of the building. There was no lift to the first floor which meant only fully mobile people could reside on the first floor as access was via the stairs. A walk in shower room had been installed on the ground floor which was fully accessible to people with mobility needs.

## Is the service caring?

### Our findings

Everyone said that they were treated with dignity and respect by staff. One person said, "It's quite pleasant here, it was better when they had less people. The best thing is they let you do what you want - obviously I can't do everything I used to do but I think they look after me well. I think they're kind."

Everyone said that their privacy was promoted by staff. People told us that staff always knocked on doors before entering and we saw this to be the case during our inspection. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. All bedrooms had their own toilet which offered further privacy to people. Staff addressed people by their preferred name which was usually their first name.

Staff understood the importance of promoting dignity, respect and independence. One member of staff said, "Always offer choices for example options of meat, fish and vegetarian meals at dinner. Make sure curtains are closed, knock on doors before entering. Encourage to do as much personal care for themselves for example passing flannel so can wash their own face."

People wore clothing appropriate for the time of year and were dressed in a way that maintained their dignity. Some people were seen wearing colour co-ordinated outfits and non-slip footwear. People's hair was clean and men were freshly shaved. Staff had ensured one person who was sitting in a chair had a blanket over their legs to keep them warm. They put soft toys next to another person who was being cared for in bed as they knew these offered comfort to the person.

People's bedrooms had been personalised to reflect their own interests and hobbies. People told us they had appreciated being able to bring items of their own furniture and make their rooms their own. People's care records were maintained in their own rooms which meant they had access to them at all times. People told us that they were able to get up and to go to bed at times that suited them and we saw this in practice during our inspection.

Effort was made by staff to build positive relationships with people who lived at the home. Staff said hello to people when they entered the room, smiled at people and checked that they were content. They also paused to speak to people who were residing in their rooms. One member of staff said, "It's important to find out people's individual needs and preferences and to respect their choices." The atmosphere in the home was very calm, relaxed and friendly. It was apparent that positive, caring relationships had been developed and that people benefited from these. Many of the people who lived and worked at the home were people who had lived most of their lives in Selsey. This gave people and staff an area in common and was heard to be a regular source of conversation.

Relatives were welcomed at the home. Relatives told us that the staff always offered them tea or coffee when they came and stayed to chat to them for a little while and they were made welcome whenever they came. Written compliments had been received from relatives thanking the registered manager and staff for events they had arranged and the care and compassion that was shown.

People's views were obtained during residents meetings and satisfaction surveys. However, these had not taken place at the frequency stated in the provider's policy. This is referred to further in the well led section of this report. Despite this, people said that the registered manager and staff asked if they were satisfied with the care they received on a day to day basis and during the inspection we saw that staff routinely checked people were happy with the support they received.

## Is the service responsive?

### Our findings

People said that in the main they received personalised care that was responsive to their needs. One person told us that they had been advised they were pre diabetic. They explained that the chef had talked through changes they could make to their diet to prevent it from escalating into full blown diabetes. When spending time another person in their room they told us that they were having difficulty breathing. We spoke to a member of staff about this who at first told us this was normal for the person. However the member of staff checked the person and reported to the senior on shift and an appointment with a GP was made.

Despite people expressing satisfaction with the care they received we found that care planning was not robust and had the potential to impact on the service people received. One person was prescribed Warfarin. There was no medicine care plan or assessment in place for this that would inform and guide staff to provide consistent care. Information about food and drinks that should be avoided when taking this medicine was referred to in the dietary requirement section of their care plans but no other information was in place. This resulted in staff having insufficient information to provide appropriate and responsive care. When asked, staff were not aware of medicine assessments or care plans being in place for anyone who lived at the home. A member of staff however, was able to explain the process in place for checking if the persons Warfarin dosage needed to be changed and the involvement of the district nurses who supported the home to manage this.

Staff informed us that another person was receiving end of life care. Their care plan was basic and only stated 'All X (name of person) food and drinks are to be thickened. Likes food sweet. When feeding use plastic spoons or a syringe. Staff to give oral care using diluted mouthwash and soft toothbrush. Monitor skin integrity, report any concerns to office or district nurse. Check what side he must be turned onto.' There was no care plan that contained specific information about management of medicines including pain relief, spiritual needs and wishes, stimulation or social contact due to being cared for in bed and their wishes upon death. We spent time with the person. They did not appear to be in pain or discomfort. However the lack of care planning meant that they may not have a pain free and dignified death based on their preferences.

A third person who moved to the home on 30 May 2017 had no assessments or care plans in place apart from a part completed initial assessment that only contained information about their address, date of birth, preferred language, GP and next of kin. We spent time with this person and found they had specific mobility and communication needs. Staff informed us about the support needs of the person which included assistance with personal care, how a stroke had affected their mobility and speech and the person liked to go outside to smoke. They confirmed care plans were not in place for any of these areas. The lack of care planning meant there was a risk that the person's needs could not be met appropriately and consistently.

Formal processes for actively involving people in making decisions about their care and treatment were either not in place or used inconsistently. There was very little evidence that people had been involved in the formulation and reviewing of their care packages. Some people had signed their care plans which indicated they had been involved in their compilation but the majority had not. Three people we spoke with did not know what a care plan was or if they had one.

Some of the care plans also contained information about people's personal and social histories. However, others did not; it was not possible to see the whole person in these documents. Daily records were completed for each person but in most cases recorded personal care tasks. This was not consistent with person centred care, nor did it provide meaningful information of the person's emotional, social and health well-being.

The lack of robust care planning meant that people were at risk of receiving inappropriate person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of robust care plans staff appeared to have a good rapport with people who lived at the home and people commented positively about the personal care they received. Staff were able to explain about people's needs and preferences. These included times they preferred to get up and assistance needed with personal care. They confirmed they obtained this information from talking to one another and not from records.

People's views about activities varied. Some people were independently mobile and were able to go out and access the community either by themselves or with the help of family. One person said, "I'm quite happy about what they're doing. I still go out regularly and see the family. I'm quite independent so don't need a lot of help." Another person said, "I like scrabble and the staff used to play with me but now I have no one to play with." A third person said, "I've done some of the art classes but it doesn't seem as if people want to join in the activities."

Information about forthcoming activities was displayed in the home, for example keep fit to music was due on the 7 June 2017. Paintings were displayed on the walls in the entrance of the home that people had completed along with small plants that people had grown. A member of staff told us that an activity was usually arranged to take place on Wednesdays and that sometimes, possibly once a fortnight someone would come in and entertain people with music. Another member of staff told us how they had taken people for cake and tea in the local area and also for a walk to a local duck pond.

An enclosed garden area was at the centre of the home and people confirmed that they enjoyed spending time using this facility. One person told us how they loved to sit and follow the sun as it moved around the garden and we saw them doing this during our inspection.

People said were aware of their rights to raise concerns or complaints and that if they had any complaints they would raise these with the registered manager. One person said, "I would talk to the manager if I had any concerns, I'm sure she would sort it out for me. My only niggle is I used to get taken out in a wheelchair by a member of staff because I can't walk far but that hasn't happened for a while now. I suppose they're too busy." A second person said "I've never complained."

Information of what to do in the event of needing to make a complaint was displayed in the home along with a suggestions box that people could post complaints anonymously if they wished. The complaints procedure included the contact details of other agencies that people could talk to if they had a concern. These included the CQC. There was a system in place for responding to complaints however no formal complaints had been raised.

## Is the service well-led?

### Our findings

People spoke positively about the registered manager. People said the registered manager was approachable and friendly and that the home was well run. One person said, "I think it's well run but I've nothing to judge it against because I've never been at another home." A second person said, "I think it's as good as they can do. There are things that we don't have but I suppose that's the same where ever you go. The carers seem to stay, so they must be quite good to work for."

Despite people speaking positively about the registered manager we found that aspects of the home were not well led. There were policies and procedures in place to help ensure quality standards were maintained and legislation complied with. However, checks and audits had not taken place in relation to all aspects of the service and had not identified the breaches of regulations we found during our inspection.

For example, a monthly quality audit was completed by the registered manager. The audit reports recorded any formal/written complaints or compliments, the numbers of people living at the home and staff levels and evidence of activities, speaking to people and staff. They also evidenced actions taken to comments made by people. From the monthly audits an annual audit summary was completed that gave an overview of people's satisfaction with the service and future improvements. The monthly audits did not include medicines management, care records and policies and procedures. As a result, the lack of medicine assessments and care plans for people had not been identified. As mentioned in the safe and responsive sections of the report some people's records were not accurate or up to date. Checks of care records had not identified people who did not have care plans or risk assessments for identified needs. Checks of policies had not taken place as a result it had not been identified that the provider's policy in relation to mental capacity was incorrect. As a result, mental capacity assessments had not been completed when needed.

The provider's falls prevention policy stated that annual audits of the management of slips, trips and falls would take place along with monthly checks to see if effective control measures reduce incidents. These had not taken place.

The providers quality assurance policy stated that reviews of peoples care packages would take place in consultation with the person and their representatives. There was little evidence of this. Also the policy stated that residents meetings would take place on a monthly basis. Three meetings took place during 2016, one in 2017 with another arranged for 15 June 2017. The frequency of meetings was not in line with the providers own policy.

The lack of effective quality monitoring in the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not ensured statutory notifications were submitted to CQC in line with legal requirements. As a result of looking at people's records and talking to staff we identified a number of occasions when events had occurred that were reportable to us. For example, when people had sustained

injuries that resulted in medical attention from emergency services and at a hospital's accident and emergency department. Members of the management team confirmed none had been submitted. This meant that CQC were not aware of serious incidents and were not able to check that the provider had taken appropriate actions to keep people safe.

The failure to notify CQC about serious injuries was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff were motivated and told us that management of the home was good. They told us that they felt supported by the registered manager and that they received supervision, appraisal and training that helped them to fulfil their roles and responsibilities. One member of staff said, "I get 100% support from X and X (members of the management team). For example with training or if I have any problems or issues they are very supportive." Records confirmed that staff meetings took place in order to keep them informed of aspects of the service and their responsibilities.

People's views were obtained in the form of questionnaires to help drive improvements at the home. Of the seven surveys completed in May 2016 six people commented about a lack of access to the wider community and social outings. They rated all other aspects of the service as either excellent or good. In response the registered manager arranged for more opportunities to visit venues in the local area, improved access in and out of the home and provided information about forthcoming events. This showed a commitment to listen to and act on the views of people and to drive improvements on the service they received.

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 18 Registration Regulations 2009 Notifications of other incidents  The registered person had not notified the Commission of incidents in line with the requirements of registration. 18.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care  The registered person had not appropriately assessed or planned the care and treatment of people to meet their needs and reflect their preferences. 9(1).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  The registered person had not ensured care and treatment of people was provided with the consent of the relevant person. Where people were unable to give consent because they lacked capacity to do so the registered person had not acted in accordance 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 registered person had not ensured care and treatment was provided in a safe way to people. They had not assessed the risks to

people and done all that is reasonably practicable to mitigate any such risks. 12(1).

## Regulated activity

Accommodation for persons who require nursing or personal care

## Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered person had not ensured systems or processes were established and operated effectively to assess, monitor and improve the quality and safety of services provided to people. They had not ensured accurate and complete records for people were maintained. 17(1).