Mrs Christine Lyte

Eastwood House

Inspection report

Eastwood Care Home
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Tel: 01472278073

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 September 2018 and was unannounced on the first day.

At the last inspection in August 2017, we rated the service requires improvement. We found breaches in regulations which related to information in care plans, consent and overall governance of the service. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective, Responsive and Well-led to at least good. Whilst we found some improvements in aspects of care recording, there were some continued concerns with consent and governance. We identified new concerns in relation to the management of risk, medicines, staffing and notification of incidents. At this inspection, we have rated the service as requires improvement again.

Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive and we found systems in place to ensure improvements were made and sustained were not fully effective. As this is the second time in a row the service has been rated Requires Improvement, we will meet with the provider to discuss their action plan for improvements.

Eastwood House accommodates up to 19 elderly people. The building is a converted domestic house that has been extended. Bedrooms are provided on both the ground and first floors with access via a passenger lift. There is a lounge and conservatory area that is used as a dining room. At the time of this inspection 17 people were using the service.

Eastwood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service was owned by an individual person and they were the registered manager. They also managed their other care service in Lincolnshire. We have referred to this person as the provider throughout the report. 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 home is run. The provider had appointed a deputy manager to manage the day to day running of the service, this had been a long standing arrangement.

We found the application of mental capacity legislation remained inconsistent. Documentation showed some capacity assessment and best interest decision-making records had not been completed appropriately. It was not clear if some people had legal representatives appointed to support them or make decisions on their behalf. We found some people may meet the criteria for a deprivation of liberty safeguard but this had not been completed.

There was a lack of robust risk management; areas of risk had not been accurately assessed and planned. There was a lack of systems to check on-going concerns. This related to the environment, equipment used in the service and people's individual risk assessments. There were shortfalls with the management of medicines and some people had not received their medicine as prescribed due to staff error.

We found there were shortfalls of staff on duty during the day, this had impacted on observation of communal areas at specific times of the day to prevent accidents and distract people whose behaviour could be challenging.

Although the provider had put a new audit programme in place, we found some continued concerns regarding effective quality monitoring. Shortfalls had been missed when audits were completed or action plans had not been put in place to address all the improvements needed. Examples included care records, the environment and accident analysis. We also found the office and recording systems were disorganised.

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

The provider had failed to ensure all statutory notifications of events in the service had been submitted to the CQC. We are dealing with this matter outside the inspection process.

The staff supervision programme and been inconsistently maintained and not all staff had received their annual appraisal. Staff had access to a range of training. There were some shortfalls and delays with staff completing some courses or refresher training. Although staff had completed training in mental capacity legislation, we found their understanding was limited. We have made a recommendation that the provider follow through with improvements to the training, supervision and appraisal programmes to ensure that identified gaps are addressed quickly.

Staff were responsive to people's needs and supported them in an individual way. They knew people very well and could describe in detail the support they required. People and their relatives had only positive comments about the staff approach and described it as caring and kindly. We observed staff were friendly and attentive to people and their relatives. Improvements were needed with aspects of their communication and how they ensured one person's privacy as this person was upset with other residents entering their room on a regular basis.

New care plan documentation had been put in place and the quality of person-centred records had improved to support the consistent delivery of care which met people's preferences.

Recruitment systems remained safe. Staff turnover at the service was low and provided continuity of care for people.

People's health care needs were met and they had access to community health care professionals who visited the service to provide treatment and advice. We received positive comments from visiting professionals about the service and the standards of care. People could remain in the service for end of life care if this was their choice.

People's nutritional needs were met and they liked the meals provided. There was plenty to eat and drink. People were provided with a good range of fortified snacks.

A new activity coordinator had been employed and people had more opportunities to participate in a range

of activities and receive social stimulation.

The environment was clean and tidy and staff had access to personal protective equipment to help prevent the spread of infection.

The views of people and their relatives were sought during care reviews, resident meetings and surveys. There was a complaints procedure displayed in the service and people felt able to raise concerns and complaints.

Staff found the provider and deputy manager approachable and felt confident they could go to them for advice and guidance.

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.

Risk was not sufficiently managed. Not all areas of risk had been identified in the service or control measures were not adequate, which placed people at risk of harm. Staff had received safeguarding training and knew what to do if they witnessed abuse or poor practice.

The system to manage medication was not always effective as some people had not received their medicines as prescribed.

Although staff were recruited safely, there were shortages of care staff during the day.

The service was clean and staff had access to personal protective equipment to help prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There had been inconsistent application of mental capacity legislation, which meant best practice guidelines had not always been followed when people lacked capacity to make their own decisions. Staff understood the need to gain consent before care and support was provided.

Staff had access to a range of training although there were shortfalls and delays with staff completing some courses or refresher training. There were some gaps with the supervision and appraisal programmes.

People's health care and nutritional needs were met. They had access to a range of health professionals in the community. Menus provided a variety of meals with choice and alternatives. People liked the meals they were provided with.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed examples of positive interactions and caring support provided by staff. However, there were concerns identified in some staff actions and communications which affected people's dignity and wellbeing.

We observed most people's privacy was well respected. However, an issue with people entering a person's room uninvited required review.

Relatives described staff support in very positive ways. Staff had developed good relationships with the people who used the service and their visitors. There was a happy, relaxed atmosphere.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

A new care recording format was in place. People's needs had been reassessed and the quality of person-centred information had improved. However, there were some areas of people's safety which had not been adequately planned. This meant staff may not have full guidance to support people and important care could be missed.

People felt able to complain in the knowledge any concerns would be addressed.

A new activity coordinator had been employed and people had more opportunities to participate in a range of activities and outings.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a quality monitoring system in place which included audits and seeking people's views about the service. However, the system was new and the audits had not always identified shortfalls or when they had been identified, these had not been resolved in a timely way. There was limited analysis of accidents and incidents to learn and prevent reoccurrence.

There had been a lack of oversight by the provider in checking the recording systems at the service. Required notifications had not always been sent to the CQC about incidents which happened at the service which affected the wellbeing of the people who lived there.

Staff told us the deputy manager and provider were approachable and would listen to any concerns they had.

Eastwood House

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 comprehensive inspection took place on 13 and 14 September 2018 and was unannounced. On the first day of the inspection, the team consisted of two inspectors and an expert by experience. The second day of the inspection was completed by one inspector.

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

We contacted the local authority safeguarding and commissioning teams. We also contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. Information provided by these professionals was used to inform the inspection.

During the inspection we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service. We observed staff interacting with people and the level of support provided to people throughout the day, including activities and meal times.

During the inspection we spoke with six people who used the service, four of their relatives and two visiting professionals. We also spoke with the provider, two senior care staff, two care workers, the cook and the activity coordinator.

We looked at six people's care records, three staff recruitment files and reviewed records relating to the

management of medicines, maintenance of the premises and equipment, complaints and staff training and development. We checked how the provider and deputy manager monitored the quality of the service; we also looked around the environment.

Requires Improvement

Is the service safe?

Our findings

There were a number of areas within this key question where we identified concerns.

We found there was a lack of oversight regarding the management of risk. There were risk assessments completed for skin integrity, moving and handling, the use of bed rails, nutrition, choking and falls. However, we found the risk management of falls was not managed consistently. Records showed one person had experienced a significant number of falls, which had led to regular injuries such as bruising and skin tears and on one occasion they sustained a fracture which led to hospital admission. Despite this, we found the person's risk of falling had been reviewed and recorded as 'low' on the falls risk assessment. Although the staff had referred the person to the falls team for assessment, there was little evidence of the review of control measures in place to mitigate risks of further falls. There was no consideration for the use of sensory equipment or increased monitoring by the staff. Observations during the inspection showed the person regularly approached other people who used the service to touch them or take their belongings which upset them. This also posed a risk to the person yet there was no assessment or care plan in place to direct staff to mitigate this risk.

One person who used the service demonstrated distressed and anxious behaviours which had on occasions caused injury and upset to other people. For this person, risk had not been managed safely and a behaviour management plan was not in place to guide staff when supporting them with distressed behaviour.

Some people were identified to be at risk from pressure ulcers and were provided with pressure relieving air flow mattresses. We found three people had mattresses that were not set correctly for their weight. This placed them at risk of skin damage. Staff were not aware of what the right setting should be and this information had not been recorded as part of the risk management plan for people. Action was taken at the time of our inspection to correct this.

Risks in the environment had not been managed appropriately to ensure people were safe. For example, safety latches for two bedroom windows on the first floor were not in working order and there was no risk assessment to support the use of the stair gate fitted at the bottom of the stairs. One person's bedroom door was wedged open which compromised the fire safety systems in place. A fire seal on a bedroom door had come loose and was repaired during the inspection. Toiletries were left out in people's rooms so these were accessible to people and could be dangerous if ingested, staff took action to store these safely.

We were concerned some people were not given their medicines as they had been prescribed by the doctor. For example, one person had been prescribed a course of antibiotics to be taken three times a day and this had been given four times on four days. Another person was prescribed pain relief medication to be taken three times a day and had been given this four times on nine days. A third person's medicines had been given yet the doctor had prescribed it to start when the course of another medicine had been completed. Not giving these medicines as prescribed posed a risk to the safety and wellbeing of the person.

We found staff did not always complete medication administration records (MARs) accurately to reflect the

treatment people had received. For example, we found gaps where staff had not signed to confirm that a medicine had been given or entered an appropriate code to record non-administration.

Some people were prescribed medicines to be taken as and when required (known as PRN). We found there was a lack of supporting information to guide care staff on how and when to administer these medicines, for example the minimum dose interval or what action to take if the medicine was ineffective. This had been a recommendation at the last inspection and we found staff had introduced a PRN record, which detailed when the medicine had been given but did not provide any guidance on administration. This was addressed during the inspection. Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. We found creams for two people remained in use although the expiry date had lapsed.

Accident and incidents were recorded, but the records were not reviewed effectively to ensure all appropriate action had been taken. A new accident and incident overview record had been put in place since the last inspection, but this was not completed accurately and there was no analysis of the incidents to inform the provider about patterns and trends.

The above evidence showed there was a breach of regulation 12 (Safe Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection there were 17 people who used the service and levels of two care workers were provided on each shift, with the deputy manager providing support during the day and an additional care worker on duty between 4 and 7 pm. The rota did not show when the deputy manager completed their management duties. There was no evidence that staffing levels had been adjusted or that some planned absences covered. Rotas showed there had been shortfalls of care staff in recent months on the 4-7 shift and shortfalls of cleaning and cook hours, which had not been covered by additional staff and care staff had completed these duties. The provider was unable to show us that the dependency levels in the service had been monitored regularly and these were factored into the staffing calculations.

On the first day of the inspection, we observed staff struggled to manage their duties and to monitor one person who was wandering continually. Staff told us there were six people who required two staff for personal care support and the cook and housekeeper provided monitoring support when they could, if there were only two staff on duty. Staff told us some days were difficult and other days more manageable with the current staffing levels in place. All staff confirmed there were not enough staff on duty during the day to monitor the person who continually wandered. Most relatives we spoke with considered more staff were needed. Comments included, "Not always enough staff. Only two carers on in the afternoons sometimes and there is nobody around" and "No, at lunch there is not enough and from my point of view not enough daily."

Not ensuring there was sufficient staff on duty at all times was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have directed the provider to take at the back of the report.

On a more positive note the home had recently recruited a new activity coordinator to work 20 hours a week and the feedback about the person's appointment was very positive.

People who used the service told us they felt safe at Eastwood House. One person said, "I know and trust the staff, that makes me feel safe." A relative said, "Totally safe, there is somebody here day and night; never felt otherwise."

Suitable recruitment procedures were in place and had been followed when recruiting the new employees. Appropriate checks were carried out including the provision of two references, and checks carried out by the Disclosure and Barring Service (DBS). The DBS included a police check to identify any cautions or convictions. This information helped employers to make safer recruitment decisions.

In discussions, staff were clear about how they safeguarded people from abuse. They had completed safeguarding training and could list the different types of abuse and describe the signs and symptoms which may alert them to concerns. They told us they would report any concerns to the deputy manager or the provider who they were confident would deal with any issues promptly and appropriately. Staff were also aware they could report concerns to other relevant agencies. Records showed the service had reported all safeguarding incidents to the local safeguarding team with the exception of one. This shortfall is covered under the well-led key question.

The service was clean. We identified an odour in one person's room which staff confirmed they were trying to address with more regular cleaning. The laundry had appropriate equipment and supplies to ensure soiled linen was washed correctly. Improvements had been made to provide a curtain to cover the shelves where clean laundry was stored, which reduced the risk of cross contamination.

Systems were in place to ensure equipment such as hoists, slings, fire equipment and the lift were in good order and serviced appropriately. In addition, there was a business continuity plan in place to ensure that people had a safe place to take shelter if they could not remain at the home. People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency. Staff were clear what to do in an emergency such as fire. All fire exits were clear.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in August 2017, we found there were shortfalls and inconsistency with the application of mental capacity legislation; decisions about care and treatment had not been recorded appropriately. At this inspection, we found only limited improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the application of MCA remained inconsistent. Many of the MCA assessment and best interest meeting records in place supported multiple areas and restrictions on the same document. These records need to be decision specific. A significant number remained in place from the last inspection and had not been reviewed. The best interest decision records for one person showed decisions had recently been made about the use of a lap strap, bed rails and the move from single accommodation to shared accommodation by the deputy manager, there was no evidence on the record of involvement in the decision making of other relevant persons.

Some consent forms in people's care files had been signed by family members, but there was no clear indication as to whether the family member was the person's Lasting Power of Attorney (LPA). A LPA is a person that has been appointed by the person to help them make decisions or to make decisions on their behalf.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS had been submitted to the placing authority; five had been approved and six were awaiting assessment. However, we had concerns that there were three other people whom we felt should have been assessed to see if they met the criteria for a deprivation of liberty safeguard. Staff told us these people did not have capacity to make decisions and records in their care files supported this. Staff also said they would not be safe to leave the building on their own. Records also showed there had been delays with DoLS applications being made.

Staff were not sure which people had DoLS authorisations granted. Social care professionals we contacted considered staff at the service had a limited understanding of MCA and they were having to prompt the service to complete DoLS applications.

Not working within the principles of MCA is a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have directed the provider to take can be found at the end of this report.

The deputy manager used a computerised training matrix to monitor the training staff had completed and when it required updating. The provider told us the matrix was not up to date and an updated version was

provided following the inspection. The training record showed most staff had completed essential training, although six staff had not completed training in dementia. There were gaps in refresher training for fire safety and infection prevention and control.

Staff were not able to consistently show their understanding of the MCA. Some staff were also unsure what DoLS meant and why this may be implemented in a care setting. We could therefore not be sure that training provided in this area was effective.

Staff told us the deputy manager was supportive. We received mixed views from staff about their training and support; one member of staff said they often had to wait a long time for training and others said they received good support and training. The provider confirmed six members of staff had attended an appraisal meeting with the deputy manager since the last inspection, which was less than 50% of staff employed. The supervision records were not available and this information was provided after the inspection. Most staff had received supervision but the frequency of meetings was inconsistent and limited for some staff.

It is recommended the registered provider follow through with improvements to the training, supervision and appraisal programmes to ensure that identified gaps are addressed quickly.

Community health professionals were involved with people's care and treatment and staff contacted them when required. We saw advice and guidance from GP's, community mental health teams, occupational therapists and dieticians. Visiting health professionals told us they were often asked to visit people to provide treatment. They all said they had no concerns regarding the care and support given to people. Comments from health and social professionals included, "The care staff know the residents, during reviews when asked questions they are always answered appropriately" and "I think the care at Eastwood House is very good."

People's nutritional needs were assessed and a screening tool was used to identify any concerns. Staff monitored people's weight and referrals were made to health professionals when required. Staff were very proud that one person who had moved to the service some months ago with low weight had significantly increased their weight since admission. The cook told us they regularly asked people if they enjoyed their meals and checked out any meal preferences with them. Menus had recently been reviewed. Special diets were catered for and diet notification records informed the kitchen staff of people's food preferences and nutritional needs. Not all the notification sheets had been provided which the cook said she would follow up.

The meals looked nicely presented. Meal times were an enjoyable and inclusive experience for the people who used the service. Tables in the conservatory were nicely set and people were encouraged to eat together. When people required assistance, or prompting to eat their meals, staff sat with them and encouraged them to take an adequate diet. Drinks and snacks were served in-between meals and we noted the range of high calorie snack options had improved since the last inspection.

People and relatives gave us consistently positive feedback about the meals served at the home. Their comments included, "Food's pretty good and the cook is good", "They always eat everything" and "They love the food, I ask them all the time."

Since the last inspection improvements had been made to the conservatory, the staff had reduced the amount of memorabilia in this area and a new roof and window blinds had been provided. People's bedrooms were personalised to their individual tastes. The garden areas were safe and attractive, we observed people regularly spent time there. We saw some redecoration and refurbishment work had been

completed since the last inspection but further work was required. The provider confirmed some of the work was planned and following the inspection they completed a full audit of the premises.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us they were supported by caring staff. Comments from people included, "They are all smashing girls" and "I am very happy here. The staff come and sit with me. They are lovely and kind."

Relatives we spoke with told us their family members were treated with kindness and compassion. They told us, "All the staff are very caring, friendly and knowledgeable. They make everyone feel part of the family here", "Staff are caring, thoughtful and interested" and "The girls are all very pleasant and efficient. [Name of family member] is always smiling, they are so happy and settled here."

Visiting professionals said, "I truly feel that Eastwood goes above and beyond to meet the needs of the residents who reside within the placement", "The relationships between the care staff and the residents are really positive. I think Eastwood is all about the people and knowing them" and "Staff are caring and compassionate."

During the inspection we observed staff interactions were mainly positive and supported people's privacy, dignity and wellbeing, but some improvements could be made. Staff knocked on people's bedroom doors before entering and in discussions they were clear about how they promoted privacy and dignity. Staff consulted people discreetly about their continence needs and supported them with their personal care in private. However, one person and their relative told us about other service users regularly entering their room, which upset them. We observed this during the inspection. Staff were aware of this issue and confirmed they monitored this as much as they could. We asked the provider to consider measures which would better support the person's privacy.

During lunch on the first day we observed a care worker blow on a person's pudding to cool it down, which did not preserve the person's dignity. When people were supported to move using mobility aids such as hoists, staff were generally patient, explained what was happening and provided lots of reassurance during the transfer. But, we observed an instance when staff were transferring someone using a hoist in a communal area and the explanation and interaction was very minimal. Also, the members of staff did not prepare the manoeuvre well and during the transfer the hoist knocked the leg of a person sitting in their chair close by.

Staff had developed positive and caring relationships with people. Generally, we observed staff communicated very well with people. We saw staff had good eye contact and often crouched or knelt to speak with people so they were at the same level. We observed staff used appropriate touch, gently rubbing a person's arm or holding their hand, which helped them to feel at ease. On one occasion, a member of staff spoke very openly about a person's condition in front of them and we felt this could have been managed more sensitively.

There was a friendly and homely atmosphere at the home and relatives could visit without restriction and were greeted warmly by staff. Relatives praised the communication and support they had from the deputy

manager and staff. They felt informed and involved in their family members' care. The service encouraged continued contact with friends and family, which helped to reduce anxiety for all involved. One relative told us, "Staff are always pleased to see us and very welcoming" and "The care plan was reviewed about six weeks ago with us."

We observed staff had developed relationships with the people they supported. They knew people well and could describe their care needs and wishes. Staff respected and promoted independence by encouraging people to do as much as possible for themselves. Although staff were busy, they made time to talk on a one-to-one basis with people when they had time. When staff talked to us about individual people they did so in a caring way.

People who used the service were appropriately dressed in clean clothes and footwear. Staff had paid attention to brushing people's hair, ensuring they had their dentures in and were wearing glasses when required. Some of the ladies wore jewellery.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Most care staff had completed equality and diversity training. Our observations of care, review of records and discussion with the provider, staff, people and visitors demonstrated that discrimination was not a feature of the service.

There were people within the service who had support from advocates in making their needs known and with decisions. This support was documented within their care file.

We saw people who used and visited the service were provided with a range of information. Records in the service were held securely and only accessed by people who required them. Staff personnel records were held at the main office. The home computer was password protected.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in August 2017, there were concerns people's needs were not properly assessed and care was not planned to meet people's needs in the way they preferred. At this inspection, we found improvements had been made and the provider was no longer in breach of this regulation, however further improvements were required to ensure people's care plans accurately reflected their needs.

The deputy manager had reviewed the overall assessment and care planning process and taken the decision to update the recording systems in place. A new care plan format had been introduced and senior staff had completed a reassessment of each person's needs and re-written their care plans.

Care plans were personalised and included people's preferences about personal care and communication needs. This included key information about people's preferred daily routines. The care plans contained information to guide staff to provide care and support along with information on people's likes and dislikes. This enabled them to deliver specific individual person-centred support. For example, one person's care plan for personal care detailed the colour and style of clothes they preferred and during the inspection we noted they were dressed accordingly. We found some areas around people's safety had not been adequately planned and this is covered in the safe key question.

There was evidence of care plans being updated in response to people's changing needs identified through on-going monitoring and review. The visitors we spoke with said they had seen, read or contributed to their relative's care plan and they felt involved in care and support decisions. We also noted that advocates had also reviewed the care records for people they supported.

At the time of our inspection, no one was receiving end of life care. People had their wishes with regards to the care they would like to receive at the end of life recorded in their care plans. Staff told us they had supported people at the end of their lives and felt people received care in line with their wishes.

A health care professional we spoke with during the inspection confirmed staff were responsive to their patients' needs and they were satisfied with the standards of care. They told us, "I visit regularly and our team are happy with the standards of care here. Staff demonstrate the 6C's [care, compassion, competence, communication, courage and commitment - the values of Compassion in Practice, a national strategy for nursing and care staff] really well here."

People told us they received personalised care and support that met their needs. One person told us, "I am very happy with my care. I am looked after very well and they do things just as I like them."

The provider was aware of the need to make sure information was presented in an accessible format for people who used the service to make decisions about their care and support. People's sensory loss and communication needs were identified in assessments and recorded in the person's care and support plan, providing clear instructions for staff on how best to communicate with the person. The provider confirmed they could provide information in different formats when requested and understood how more pictorial

information could better support people living with dementia.

People were complimentary about the new activity coordinators support and the activities provided. People and their relatives felt there hadn't been much going on before and staff struggled to provide activities when the coordinator was not on duty, due to all their care duties. The activity file showed gaps in records between June and September 2018, where no activities had been recorded. The activity coordinator told us how they were getting to know people and we observed they spent one-to-one time with people during the inspection, doing hand massages, nail care, playing skittles and talking with them about their families. They explained they didn't yet have a programme in place and were flexible and responsive to people's requests. The coordinator told us they also supported people to participate in card and board games, ball games, drawing and dominoes.

People's diverse needs and preferences were assessed and planned for to ensure they received a personalised service. For example, one person's religion was very important to them and we saw this was clearly recorded and staff were aware. The home facilitated visits from their minister and ensured they could listen to religious songs when they chose. We spoke with the person's minister during the inspection who confirmed the staff accommodated their visits well; the person had settled well into the home and was thriving on all the care and attention provided.

People and relatives knew how to raise concerns and complaints and felt able to do this when required. A relative said, "I would be quite happy to raise any concerns with [Name of deputy manager]." Information on how to make a complaint was available to people and on display in the entrance hall. There were no records of any complaints received since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in August 2017, there were concerns that effective governance systems were not established and operated within the service; shortfalls were found in relation to the care records including consent, staff training and the environment. At this inspection, we found limited improvements and continued shortfalls in the service as evidenced by the new regulatory breaches cited in this report.

Following the last inspection, the provider confirmed they would spend more time in the service monitoring the day to day management and improvements needed. Although the provider had visited the service more regularly, there was little evidence they had completed thorough checks of the administration and recording systems, which they acknowledged. The deputy manager was not present for the inspection, we found the office was disorganised and the provider struggled to access many of the records requested.

The deputy manager had implemented new audit tools and a new audit programme. Although we found improvements had been made with the quality of person centred records, we found new systems used to monitor the quality of the service were not effective in identifying concerns and protecting people from risks to their health, safety and well-being. We were unable to consistently see that remedial action was taken when issues were identified. Checks on the window latches in August had failed to identify two were not working.

We looked at the arrangements that were in place for managing accidents and incidents. Most falls were logged, but there was no overall analysis of accidents and incidents to identify any emerging trends or patterns to inform risk management, prevent reoccurrence or identify any learning needs. Staff had not reported one incident to the local safeguarding team, which met the criteria for the low-level reporting system in place. The provider confirmed our findings and during the inspection confirmed they had arranged for the administrator from their other service to visit the service and collate all these records. The administrator would then visit each month to review the incident and accidents and provide a graph report for the provider to analyse and review.

The application of mental capacity legislation remained inconsistent and we found continued shortfalls in the records which supported consent to care. These issues had not been identified in the audit programme and there had been no systematic approach to making improvements.

Care plan audits had found some shortfalls but had not captured issues regarding a lack of thorough risk and behaviour management plan for one person. They had also not highlighted where risk assessments were not accurate or updated. The provider confirmed the care file audits were limited and checked for the presence of specific documents rather than the quality of what was written.

New audit checks had been completed on the environment. Shortfalls had been identified with the quality of some furnishings and décor, but no action plans were in place. Following the inspection, the provider confirmed they had completed detailed checks of each room and developed a renewal programme. The pressure sore audit in August 2018 identified a person had developed some skin damage yet there was no

review of equipment and support in place or action plan developed.

We had concerns about effective recording systems within the service. Many records were not easily accessible, accurate or up to date. Staff rotas did not detail people's full names or role. Training records were not up to date and staff supervision records were not available during the inspection. The bowel monitoring records for people were not maintained consistently.

This demonstrated a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have directed the provider to take can be found at the end of this report.

Since the last inspection we recognised that the provider had failed to notify us of all deprivation of liberty safeguards, safeguarding incidents, injuries and the deaths of three people. This was a breach of regulations. The provider accepted a fixed penalty and paid this in full.

Following the inspection, the provider confirmed they had met with the deputy manager to discuss the improvements needed and changes that would be made. The deputy manager was allocated three days a week for management duties which would be recorded on the staff rota and monitored by the provider. Recruitment of new care staff was underway. The provider had reorganised the office and had ordered a new computer. Changes were being made to many of the audit formats to ensure they were more effective.

The deputy manager had systems in place which sought the views and opinions of the people who used the service and their relatives. These were usually in the form of surveys but meetings were also held. People and their relatives were generally positive about the management of the home. They found the deputy manager approachable and could express their views about how the service was run. Comments included, "All the staff do a fantastic job, they feel as though it is family", "Yes the service is managed well, but I would put more staff on at times", "Looks like it's all as it should be" and "I completed a survey and mentioned the lack of activities and this is improving."

Staff meetings took place each month and topics discussed were recorded. These included team work, job roles, training, cleaning procedures, medicines, service users, safeguarding and confidentiality. All the staff we spoke with told us they found the deputy manager supportive and they were very visible around the service. Staff told us the provider visited regularly and they were approachable. Comments included, "You can always go to [Name of deputy manager] and they will listen to you", "The owner comes a lot, she's lovely. Her husband comes often too and deals with all the maintenance" and "I can go to both if I need support or advice."

The deputy manager and staff team had developed good links with other health and social care professionals involved in people's care and treatment. They referred to specialist teams and had reviews of people's care with community nurses and social workers.

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 11 HSCA RA Regulations 2014 Need for consent The registered provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when people were unable to give consent because they lacked capacity. Also they had not consulted with the local authority when there was the possibility some people met the criteria for a deprivation of liberty safeguard. Regulation 11(1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured risks to people's health and safety were appropriately assessed and steps to mitigate any such risks had always been taken. Also they had not ensured medicines were safely managed. Regulation 12 (1) (2) (a) (b) (d) (e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured adequate systems were in place to monitor and improve the quality of the service delivered to people. Also to ensure there were accurate records relating to people.

Regulation 17 (1) (2) (a) (c) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons were always deployed to meet people's needs. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services Provider failed to notify us of a number of deaths.

The enforcement action we took:

We issued a Fixed Penalty Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Provider failed to notify of serious injury, DoLS and safeguarding incident.

The enforcement action we took:

We issued a Fixed Penalty Notice.