MyMil Limited

Scraptoft Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 March 2017 and was unannounced. We returned on the 9 March 2017 announced to complete the inspection.

Scraptoft Court Care Home provides residential and nursing care for up to 34 people. The home specialises in caring for older people including those with physical disabilities, people living with dementia and those who require end of life care. At the time of our inspection there were 29 people in residence.

At our last comprehensive inspection in April 2015, the service was rated as 'Requires Improvement'. We undertook a focused inspection of the service in December 2015 to check that the registered persons had followed their plan of action to meet the legal requirements. We found the service had made the improvements. We were unable to change rating as these improvements needed to be sustained

A registered manager was in post. 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.

We found that further action was needed to ensure people's health, safety and wellbeing was maintained. We found the management of medicines was not safe and staff did not follow infection control and prevention procedures and did not move people safely. Risks associated with people's individual health needs had been assessed and, advice sought from health care professionals. However, we found staff did not always support people to be positioned correctly to eat. Staff did not always follow advice in regards to preventing people from the risk of choking because people's drinks were not always made up with the thickeners in accordance with prescriptions.

We found the provider's governance system was not used effectively to monitor or identify shortfalls that we found during this inspection and to drive improvements.

People's care needs had been assessed and measures to manage risks were put in place. Most staff understood people's needs and the support they required. People were involved and made decisions about their care and support needs. Care plans were focused on the person and incorporated advice from health and social care professionals. People's care plans and risks were reviewed but not always in a meaningful way as some lacked detail about changes to people's needs and did not show the involvement of the person or their representative. Where changes had been identified people's care plans were not always amended to reflect those needs. Despite this staff were kept up to date about changes to people's needs through the daily handover meetings.

People told us they felt safe with the staff. The registered manager and staff were trained in safeguarding adults, understood their responsibilities in this area and were aware of the procedures to follow if they

suspected that someone was at risk of harm.

Staff were subject to a thorough recruitment procedure that ensured care staff and nurses were qualified and suitable to work at the service. The registered manager ensured there were enough staff to meet people's needs and used agency staff to manage absences. Staff received training, support and supervisions in order to meet people's needs effectively. The registered manager provided clinical support to staff to ensure they were competent and their practice was safe.

People told us they were provided with a choice of meals that met their dietary needs. People were asked for their views about the meals provided and their preferences were taken into account in the menu planning.

The registered manager and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were dedicated in their approach to supporting people to make informed decisions about their care. Assessments to determine people's capacity to make informed decisions about their care had been undertaken.

People told us staff were kind and caring towards them. Most staff knew how to support people living with dementia and reassured people when they became upset or needed assurance. People and their relatives had developed positive relationships with staff and were confident that they would address any concerns or complaints they might have.

People's lifestyle choices respected. People maintained contact with family and friends and took part in social events and activities that were of interest to them.

People's views and opinions of their relatives were sought in a number of ways including meetings and surveys.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Medicines were not stored or managed safely. Risks were assessed and plans in place to support people. However, improvements were needed to ensure measures to manage risks and to keep people safe were being followed. Further actions were needed to ensure staff assisted people to move safely and that staff followed the service's infection control procedures.

People were protected from abuse because staff were trained and systems were in place to protect people from abuse. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained and being supported in their role to provide the care and support people required. Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff sought people's consent. Care plans showed people or their representatives were not always involved in making decisions about all aspects of their care and support.

People's dietary needs were met. Effective monitoring of people's appetite and assessment to ensure people's health was not always maintained by the support provided. People had access to a range of health care support to meet healthcare needs.

Is the service caring?

Good

The service was caring.

Most staff had developed positive working relationships with people, which was supportive. People's wellbeing was promoted by staff that offered assurance and comfort in a meaningful way. People were involved in making decisions about their daily care needs. Staff promoted people's rights and dignity. Staff ensured people were comfortable and pain free towards the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's assessed needs were met when they moved to the service. Care plans and risks were reviewed but not always in a meaningful way and care plans not always amended when people's needs changed.

People maintained contact with family and friends, and participated in activities of interest to them. People knew how to complain and were confident that their concerns would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

A registered manager was in post. Further action was needed to implement fully the provider's governance system to help identify, improve and monitor the effectiveness of the care provided. This supported the issues identified by commissioners that monitor the care of some people who they fund.

People, relatives and staff felt involved and their views were sought about running of the service.

Scraptoft Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection which took place on 8 March 2017 and was unannounced. The inspection team consisted of an inspector, a specialist nurse advisor and an expert by experience. This specialist nurse adviser was a qualified nurse who had experience of working with older people. The expert by experience's area of expertise was the care of older people and people with dementia. The inspector returned announced on 9 March 2017 to complete the inspection.

Before the inspection, the provider completed 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.

We reviewed the information we held about the service and the notifications. A notification is information about important events and the provider is required to send us this by law. We contacted health and social care professionals and commissioners for social care responsible for the funding of some people's care that use the service. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. This information was used to plan the inspection.

We used a variety of methods to inspect the service. We spoke with four people using the service and four relatives to gain their views about the service. Most people who used the service were living with dementia. Therefore we used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who used the service. We spoke with the registered manager, deputy manager, three nurses and a senior carer, two care staff, the administrator and the quality manager.

We looked at the records of 11 people, which included their risk assessments and care plans, and the medicine records. We also looked at the recruitment records for four members of staff and the training

records. We looked at some policies, procedures, complaints logs and other records that showed how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We found people's medicines were not managed or stored safely. The treatment room had been left unlocked and unattended by staff in the morning. There was suitable storage for medicine which had to be tightly controlled otherwise known as controlled drugs (CD) and a medicine fridge but both were left unlocked. We found prescribed cream and an ointment were left on a tray on the worktop. These medicines were easy to access by people and visitors. There were high temperatures recorded for the treatment room, which could alter the effectiveness of the medicines. We found two insulin pens without names or any form of labelling. We found eye drops in the fridge that had not been dated when opened, this is important because these only have a shelf life of 28 days. That meant staff would not know when the 28 days had passed. When we asked a nurse about the undated eye drops in use they said, "I left it for [another] nurse to check as she was cleaning out the fridge." We had to alert the registered manager that the treatment room had been left unlocked and the medicines accessible.

The service used an electronic medicine administration system. Nurses and senior staff told us they had been trained to use the electronic system to administer and complete records to confirm the medicines were taken. However, we found gaps in the medicine records for eight people. For example, there were a number of missing signatures for someone prescribed medicine to prevent blood clots, and for another person who had been prescribed eye drops. This meant we could not be sure that these people had had their medicine when they needed them. People who were prescribed topical cream had a body map attached to their medicine record but there was no information about where the creams should be applied. This meant staff might not know where the creams should be applied. These shortfalls could result in people's health being put at risk as their prescribed medicines and creams might not be administered as prescribed.

The provider's medicines policy for medicines administered 'as required' (otherwise known as PRN) stated that a 'prn administration plan should be kept available at all times for the purpose of cross reference' and ' should be reviewed with the GP on a regular basis'. We found there was no PRN administration plan for one person who had been prescribed medicine for if they became distressed and had behaviours that challenged others. That meant it was not clear under what circumstance this medicine should be given.

One person had their medicines disguised in food and drink. This is known as covert administration. The person was not aware that their medicine was disguised in food and a mental capacity assessment had been completed. A deprivation of liberty safeguard (DoLS) was in place but it was not linked to the administration of the covert medicine or care plan that detailed this person's medicine administration regime. Although the nurse told us how they administered the covert medicines they were not sure whether other nurses followed the same practice. That meant the person was at risk of not receiving their medicines safely and in a consistent manner.

We found infection control procedures were not always followed correctly which put people's health at risk. Nurses and care staff did not routinely wear aprons when handling or serving meals or drinks. We saw a member of staff member placed a pressure cushion which had several tears on to a wheelchair before they

moved someone onto it. We had to intervene as the pressure cushion was unsafe. The staff member then discarded it and another pressure cushion was used.

We observed two staff prepared to transfer someone using a hoist. The sling was not placed properly around the person so they were at risk of falling or injuring themselves when they were lifted. We alerted the registered manager who was sat in the office opposite the lounge. They intervened and directed the staff so they were able to move the person safely.

Records showed a number of people were at risk of choking or had swallowing difficulties. Healthcare professionals had prescribed thickener to add to their drinks to reduce the risk of choking. Staff members showed us a list with people's names who had been assessed as needed their drinks to be thickened. However, all the drinks served mid-morning were thickened using one person's prescribed thickener. That meant people's health was put at risk because staff did not prepare drinks individually as prescribed. When we brought this to the attention of the registered manager everyone's prescribed thickeners were placed on the tea trolley and prepared correctly later that day and on the second day of our inspection visit. Ongoing monitoring would help assure the provider and registered manager that staff followed this practice at all times.

We saw a nurse supporting someone to eat who was slumped in a recliner chair. When we asked the nurse if the person was seated in a safe position to eat they said, "She always slips down." Because the person's was not sat upright the risk of choking or aspiration increased. When we intervened the nurse asked a care staff to help them to support the person to be sat up. The care staff stated that a hoist was needed and went to fetch the hoist and sling. This was an example of staff member being unclear about how to safely support a person to eat and alter their position.

We found equipment used to help maintain people's safety was not always effective. Sensor mats and cushions were used to alert staff when someone at risk of falling mobilised on their own. We saw someone still wearing their nightwear walked bare footed to the lounge. When we checked we noted that they had a sensor mat placed close to their bed but staff had not been alerted the person had got up. A staff member on induction assisted this person to be seated in the lounge. The deputy manager told us that the senior staff had the mobile device which alerted them if this person was activated the sensor mat but they had not responded as they were busy assisting someone else with personal care needs. That meant the person's health and safety had been put at risk because staff were unable to support the person in time.

All these issues were brought to the attention of the registered manager and they acknowledged improvements were needed.

This was a breach of Regulation 12 (1) (2) (b) (e) (g) (h) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's health, safety and wellbeing was put at risk because their medicines were not stored, managed and administered safely and measures to prevent the risk of choking were not managed correctly. The infection control prevention procedure was not always followed. Equipment used to manage risks and maintain people's safety was not used correctly or safely.

We asked people if they felt safe and why. One person said, "I'm safe in here as I have my walker to get me around." Another said, "Staff are here to help me and keep me safe. If I thought someone was out to hurt me I'd tell the manager." When we asked relatives about the safety within the service their comments included, "I have not seen anything that concerns me in the home and the other service user's behaviour is not affecting us." And, "There have been no incidents or concerns while he [relative] has been here. He is very safe here, I don't have any worries."

Staff were trained in safeguarding procedures as part of their induction. The provider's safeguarding and whistleblowing policies advised staff what to do if they had concerns about the welfare of any of the people who used the service. Staff we spoke with knew how to protect people from harm and were confident to raise concerns with the management team. A staff member said, "If I saw any type of abuse I would report it to [registered manager's name]. I know she will deal with it by contacting CQC and the Council. We have a whistleblowing policy if I needed to use it."

At our last inspection in December 2015 we found some people's risk assessments were not completed and lacked guidance for staff to ensure the person's safety. The registered manager assured us that they would review and amend everyone's risk assessments and care plans to ensure staff had information to support people safely.

We found risk assessments were undertaken where potential risks associated with people's physical health, care needs and safety had been identified. This included where someone was unable to walk or move independently and to meet specific healthcare needs such as managing pressure sores and wounds. For example, a wound care plan detailed the type of dressing that was used and how often the dressing should be changed. Records showed that the nurses had followed the care plan and as a result the person's skin condition had improved.

Records showed another person was assessed as requiring one to one support from staff to prevent the risk of behaviours that challenge. We saw a staff member anticipated and diverted the person's attention by singing a song to prevent them being upset. The staff member later told us that the person responded well to positive engagement such as conversation and signing which was consistent with this person's care plan. That showed staff followed the guidance in the care plans to support people to stay safe.

We found the premises and equipment used in the delivery of care such as hoists were maintained and serviced regularly. Records we viewed confirmed this which showed a system was in place to provide people with a safe environment.

People's safety was supported by the provider's recruitment practices. Staff records contained a completed application form, a record of their interview and two written references. A criminal record check had been carried out by the Disclosure and Barring Service (DBS). The DBS checks help employers to make safer recruitment decisions. A further check was undertaken for the nurses to ensure they were registered with the appropriate professional body and confirm their qualifications and suitability. That meant people could be assured staff were safe and suitable to work with them.

The registered manager told us that staffing were determined by the number of people who used the service, their dependency needs and the number of staff and the skill mix required. Assessments of people's needs identified the number of staff required to support them. The staff rota was reflective of the staff on duty and identified the staff member providing one to one support. The registered manager told us agency staff were used to cover staff absences.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in April 2015 we found there were gaps in the staff training records and no record of training updates or assessment of staff competencies. Most staff had not been appraised to ensure they had the skills and knowledge to provide effective care and support to meet people's needs.

The PIR detailed the induction and ongoing training all staff were required to complete before they commenced work. Care staff had attained a professional qualification in health and social care. This included the Care Certificate, which is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.

The staff training matrix we looked at showed that staff had received training updates related to people's care needs and health and safety. These included moving and handling, infection control and pressure care management. We had observed staff did not always put the training into practices, which we shared with the registered manager. On the second day of our inspection visit those staff were being re-trained in moving and handling.

A new staff member told us, "I've done the induction training, which included the moving and handling and using the hoist. I'm working with [senior staff's name] today so that I get to know people and how to help them." Another staff member showed a good insight into the needs of people using the service and told us how the training had helped them to provide the appropriate care. Another staff member said, "I learnt a lot from the dementia training. It's helped me especially with [person's name] who can't speak properly but if you look at their face you understand what they want." Nurses were supported to maintain their professional registration. Records showed the nurses' competency to provide healthcare support had been assessed.

Most staff said they felt supported by the registered manager and records showed their work had been appraised. A staff member told us that supervisions sessions enabled them to reflect on how their work and the impact it has on those using the service, and helped to identify training needs. Staff meetings were used to discuss the quality of the service and areas that could be improved. Action plans developed from those meetings helped the registered manager to plan training and monitor the staff skill mix to meet the needs of people who used the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found conditions on the DoLS authorisation to deprive a person of their liberty were being met. A health decision-specific capacity assessment had been completed and referrals to health and social care professionals in the person's best interest had been made. Records showed people and where appropriate their representative had been involved in decisions made about all aspects of their care and treatment. That showed the principles of the MCA were followed.

The registered manager and staff were trained in MCA and DoLS. Staff we spoke with understood the importance of people consenting to their care however this was not always followed in practice. We observed a number of instances whereby staff did not always gain consent before assisting people. For example, we saw staff approached someone from the side which startled them and another member of staff did not explain what they were about to do so the person looked confused. We shared our observations with the registered manager and they assured us they would monitor and address staff's practices.

We asked people for their views about the food and drink. One person said, "I like to have buttered toast and tea for breakfast. There's fish for lunch but I'm going to have a fish sandwich instead." Another person told us, "The food is very nice. If you don't like what's on the menu they [the cooks] will make you something else."

A relative told us that their family member had a small appetite and said, "He [relative] does sometimes decline the lunch. They [staff] know what he likes to eat so will suggest something else". Other relatives said, "The food is good. In fact since he [relative] has been here, he has put weight on" and "The food is very good, he [relative] eats well."

Most people sat in the dining room for their lunch. There was a choice of meals which were served individually. Some people had soft or pureed food due to a difficulty swallowing or risk of choking. Most people were able to eat independently or were helped by staff who for example, cut their food into smaller pieces. The dessert trolley had a selection of desserts. People chose what they wanted to eat. One person did not like the desert options so requested a bowl of ice cream which a staff member brought for them promptly.

The lunchtime dining experience over the two days differed. The first day of our inspection visit the dining room was crowded which made it difficult for the staff to move around. Some people were getting upset as they had to wait for staff to assist them. However, when someone asked to have the chips swapped for mash potatoes it was done immediately. People were not always offered second helpings. The lunch time experience on the second day was relaxed. The room was not crowded as the tables were spread out so that there was space to walk by. Staff communicated with each other and were organised. Staff assisted people individually and offered encouragement. For instance, one staff member described the food on the dinner plate to a person. Second helpings were also offered to people.

We shared our observations with the registered manager. They acknowledge the difference was a result of the staff on duty and assured us they would review the staffing and support staff to develop skills to ensure the lunchtime dining experience was positive.

Staff we spoke with aware of people's dietary needs and the support they required. A staff member said "We know [person's name] tends to eat little and often so we make sure we offer her a sandwich after a little while, then some biscuits." This person's care records showed staff monitored the amount of food and drink they ate and sought advice from the dietician to ensure their nutritional needs were met.

Records showed an assessment of people's dietary needs and their preferences and the support they

needed to eat and drink were documented. If people were at risk of poor nutrition advice was sought from the speech and language therapist (SALT) and the dietician to help to maintain people's health. We found staff did not always use people's prescribed thickeners to prepare drinks. Staff did not accurately monitor people's eating and drinking. Records showed staff had totalled up the amount someone had drunk in the previous 24 hours but there was no guidance as to the expected amount they were required to drink. People were not weighed regularly. For instance, one person's care plan stated that they should be weighed weekly but we found only three entries in total for the months of January and February 2017. Previous weeks' records had been removed from the care file and archived which meant changes were not easily identified and could put people's health at risk.

We shared our observations and findings with the registered manager. They assured us that people's nutritional needs were met. However, they said they would liaise with the nursing team and seek advice for people with specific nutritional needs to ensure the support they received was appropriate and to improve how staff monitored people's health.

People told us that the staff were proactive when people needed to see the GP or required support in a medical emergency. One person told us that they received visits from the chiropodist and the optician and said, "It means you don't have to worry about getting ready to go out when they come to you instead." People's healthcare needs were identified and their records showed people accessed range health care services to meet their health needs.

Good

Is the service caring?

Our findings

People told us that they liked the staff and felt they were treated with care. One person said, "I like living here due to the staff being quite good and looking after us." Another person said, "They [staff] do look after us well. They do a good job caring for all of us."

Relatives also found the staff to be kind and caring. One relative said, "He [person's name] likes to have banter with staff, he has a good relationship with them [staff]." Another said "The staff are friendly, helpful and nothing is too much trouble."

We observed staff interactions with people was generally caring and saw that people were mostly treated with respect. On the first day of our inspection a staff member saw that someone was uncomfortable in the chair, they offered to help the person adjust their seating position. They took care when helping the person to be seated comfortably and checked they were happy before leaving them. We also observed when someone was anxious and called out for help a member of staff offered assurance by putting their arms around them. However, at lunch time this person became distressed again and staff did little to alleviate their worries and tended to ignored them. Other person in the dining room became frustrated and shouted back which perpetuated the situation. When we shared our observations with the registered manager they assured they would address them.

The following day we observed staff involved people and their visitors in conversations and enquired about their wellbeing. The person who previously called out for help was visibly happier and engaged with staff that stopped to talk to them and stroked their hand to reassure them they were not alone. The member of staff told us that the person was living with dementia. They understood how dementia affected this person who needed a lot of assurance through conversation and by touch. That showed some staff had put their dementia awareness training into practice by their approach which resulted in promoting the wellbeing of people living with dementia.

The registered manager told us that they asked people to take part in their care plan reviews. Only a few were able to take part however due to their mental health needs. People's care records showed that they made some decisions about their care and support. Where the person was unable to make certain decisions about their care needs, records showed the person's relative or health care professionals had been involved. This supported the comments we received from relatives who said they continued to be involved in the reviews of their family member's care. A relative told us, "[Person's name] has dementia so it's important for us to know he's being cared for in a way that is right for him." This involvement helped to ensure that people's needs would be met and their daily lifestyle choices and wishes would be respected.

People told us staff supported them in a way that maintained their privacy and protected their dignity. One person said, "They will always knock before entering my room." Another person told us, "They [staff] help to wash my back but I manage to do everything else." This showed that people were supported as much as possible to maintain their independence with regards to their personal hygiene.

We saw that when a relative told a staff member to assist their family member with personal care needs the staff member knelt down so they were at the same eye level as the person seated and discreetly asked if they would like help to return to their room. This was an example of a staff member engaging with a person in a caring manner.

We saw some people wore aprons to protect their clothing from food spillages at lunchtime. That helped to maintain their dignity. We observed staff prepared to use a hoist to move a lady who wore a dress. When a senior staff member observed this they fetched a blanket which was placed over the person's legs before they were moved in order to maintain their dignity. We saw staff offered to assist people with personal care before they went to the dining room for lunch. These were examples that showed people's privacy and dignity were respected.

Staff records showed that staff had received training in topics that were related to the promotion of people's privacy and dignity. A staff member told us that people's bedrooms were respected as their own space and they sought permission before entering their rooms. The registered manager told us that as part of staff development some staff would complete the dignity in care champions' award. A dignity champion actively promotes people's dignity and their human rights in all aspects of their lives and challenges poor practices.

The PIR stated the service had been accredited with a bronze award for end of life care. Staff told us that they had supported people towards the end of their lives. They worked closely with the health care professionals and the person's family to ensure the person remained comfortable and their last wishes were respected. We found advance care plans were in place where people had made decisions about their last wishes.

Requires Improvement

Is the service responsive?

Our findings

People told us that the staff understood individual needs and preferences and felt those were met. One person told us that they were asked about the support they needed, what they could do for themselves and the role of staff supporting them. Some people expressed concerns that baths and showers were restricted. One person said, "We can only have a shower once a week as there are 29 people in here" and another told us they preferred to have a strip wash. People told us that the bathrooms were used to store for laundry and continence products. We checked the bath and shower rooms and found most were in use. The registered manager told us people were regularly offered showers and staff documented if the person declined. They told us that there were plans to convert a bathroom into a wet room and people would be consulted about this.

Most relatives told us that they had been involved in planning their family member's care and had attended care review meetings to ensure that new care needs could be met safely. A relative said "They [staff] call me with any problems. At the start, he [family member] had behavioural issues but they told me all about it and what they were doing." Another relative said, "My mum and I were shocked by what they [staff] told us. We didn't know about her health and medication changes as they didn't keep up updated." A third relative said "I was involved with the care plan at the beginning but there has not been a review recently."

Care records showed that people's needs were assessed and they were involved in the development of their care plans to ensure their needs were known, including what they could do for themselves, and their wishes in the event of a medical emergency. For some people their relatives and health care professionals were involved in care planning to ensure their needs would be met.

People's care plans and risks had been reviewed but not always in a meaningful way. One person's meeting record showed that the person and their relative had been involved the review of their care. The care plan had been amended to reflect the role of staff in meeting those new needs.

However, other care plan reviews were indicated by a handwritten note stating 'significant changes'. There were no details as to what the changes were and who was involved in the review. The care provided by staff was documented in the daily monitoring records. The previous weeks records were archived, therefore it was not clear what other information was used to assess someone's changing needs. This also supported the comments we received from the relatives who stated that they were not always involved in the review of their family member's care or kept up to date when people's needs changed. Although staff told they were aware of people's needs in general and received updates at the daily handover meeting, the most up to date care plans were always in place. That meant people were put at risk of receiving inconsistent care or not receiving the care and support they needed.

We looked at the recent contract monitoring visit report from commissioners who fund the care for some people that used the service. The report identified a number of issues which supported our findings in relation to the guidance for staff to follow in the care plans, quality of reviews undertaken and the monitoring the effectiveness of care and support provided.

We shared our findings with registered manager with regards to people's care records and asked them for an update on the improvement required by the commissioners. They also showed us the action plan which demonstrated that some issues had been addressed in relation to people whose care was funded and other improvements were still ongoing. They assured us that the service was responsive. For example, staff whose moving and handling practices had been identified to be unsafe on the first day of our inspection visit were being trained when we returned the following day to complete the inspection.

We saw a board in the corridor with a list of activities which included playing cards, artwork, movies and chair exercises. Visiting entertainers, singers and monthly holy communion was organised for people. The atmosphere over the two days varied. On the first day at times staff were not always in the main lounge, which meant that people had little opportunity to be engaged in a meaningful way or take part in an activity that was of interest. On the second day a number of people were being supported by a visiting activity group to make pompoms. There was laughter and conversations which showed people enjoyed the activity.

We asked people about the activities and how they liked to spend their time. One person said, "We have quite a few things going on. I like to be ready early so I can take part in them. I like doing the arm chair exercise classes and painting. We had a Valentine dinner recently and I'm sure we'll be making Easter bonnets." Two people commented on the outdoor space that was not used often. They said, "I would like to be able to get some fresh air and to stretch my legs." Staff member told us there had been an issue once but that did not stop people using the outdoor space on warmer days.

We saw some people were saw watching television programmes or spent time with their visitors. A relative told us, "He [family member] doesn't have any hobbies. He likes to sit in his chair which he is happy with." Another said, "He [family member] gets so many visitors I think we keep him quite busy. He likes to watch the television in his room but that's his choice."

The PIR stated that the suggestion box and a 'comment tree' where people and their relatives write comments about the service. We saw there were a number of positive comments on the comment tree about the staff and the service provided.

People told us that their views were sought individually and at the residents' meetings about a range of topics such as the meals and activities. The meeting minutes showed people expressed their opinions and raised concerns regarding the laundry. The registered manager told us that the investigation into the laundry issue still ongoing and they hoped it would be resolved soon.

People and relatives told us they knew how to complain and found the complaint procedure easy to follow. One person said, "If I did have a complaint then I'd talk to the manager, she's here most days." A relative said, "There were few minor things when he moved in nothing serious but all were dealt with when we told [registered manager's name]." Records showed one complaint was received and the complaint procedure had been followed.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service we found the provider's governance systems was not used effectively to monitor the quality and safety of the service provided. Issues were not routinely identified in order to drive improvements and help to ensure the quality of service, the environment and the care and support provided was safe and met people's needs.

The PIR demonstrated that the was provider aware of the CQC's approach to what makes a good service and clearly set out the quality of service people should expect to receive. Examples were included to support the five key questions we ask about services, is the service safe, effective, caring, responsive and well-led. It also stated that the service had made most of the improvements that had been identified at the previous inspection. The registered manager told us that they were unable to have 'champions' or lead roles for nurses in all aspects of care from dignity to continence care as they were unable to recruit enough nurses.

At this inspection despite the evidence in the PIR about the service being well-led we found management of the service, procedures, documentation and systems were fragmented. New issues were identified which impacted on people's safety and compromised the quality of care they received. We observed a culture whereby staff accepted existing practices and were reluctant to challenge or question. Although the management office was close to the communal areas, there was a lack of oversight and supervision. We observed a number of instances where we had to intervene in order protect people from further risks to their health and safety.

We found various monthly audits had been completed such as audits on the safety checks on the equipment and premises, people's care plans, medicines management, the infection control practices and daily visual checks. However, these audits did not always effectively drive improvements. For example, no one noticed the treatment room was left unlocked and that staff used someone's prescribed thickener tub to prepare drinks for everyone else. We asked nurses whether routine checks were carried out to ensure medicines were stored, managed and administered safely. One nurse said, "I don't think management do any checks. They tend to leave it for the nurses to do everything correctly."

The provider's policies and procedures had been updated and provided staff with clear guidance about their roles. Staff were aware of the provider's policies and procedures and knew what was expected of them by the provider. Despite the registered manager conducting clinical competency checks on the nurse's practice to administer medicines, we found the medicine administration procedure was not always followed.

There were no checks carried out ensure other medicines not stored in the electronic units [prepared and dispensed by the pharmacy] were stored safely and records were completed correctly. The issues in relation to gaps in the medicine administration records had not been identified through the audits which meant the provider's governance system was ineffective and not used effectively.

Records showed the audit on three people's care records in January 2017 had identified that care plans and

risk assessments were out of date in relation to people's personal hygiene, medicines and nutrition. There was no evidence as to whether these issues had been addressed and this supported our findings as similar issues were still found in people's care records that we viewed. That meant issues identified were not acted on or monitored to ensure staff had access to accurate, clear and up to date information in order to meet people's needs.

People's care needs, care plans and risks were not always monitored and reviewed effectively. For example, where it was identified that people's intake of food and drinks should be monitored. Staff documented what the person ate and drank but no one had assessed whether that was sufficient or sought advice to ensure the person's nutritional needs were being met.

Prior to our inspection visit we contacted the local authority commissioners responsible for the care of people who used the service. They told us that at the last contract monitoring visit in July 2016 where issues were identified included management of medicines, missing signatures and physical checks of the medicines in boxes were not recorded. That showed there were ongoing issues with regards to the management of medicines that the registered manager had not resolved effectively.

This was a breach Regulation 17(1) (2) (a) (b) (c) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the governance system was ineffective and the quality of service people received was not well managed.

The service had a registered manager, a qualified nurse and also the registered provider. They are the 'registered persons' with the Care Quality Commission authorised to manage the service and have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

They were supported by the deputy manager who had lead responsibility to ensure people's health; care and support needs were met and managed the team of nurses. The registered manager told us that they had recently appointed a part time quality manager whose role would include a full audit and review of people's care and support and to monitor the effectiveness of the governance system.

The registered manager understood their responsibilities in providing quality care in line with the provider's vision and values. They acknowledged that further improvements were needed in light of our observations which were shared with them.

The registered manager was aware of the CQC's approach and gave examples to support the five key questions we ask about services. They had clear visions and values about the quality of service people should expect to receive. However, it was evident from our observations that they lacked any oversight and awareness of people's experiences which meant those were values were not put into practice.

We found the provider had displayed the latest CQC inspection reports and rating, which is a legal requirement. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

We asked people who used the service and relatives for their views about how well the service was managed. One person said, "It can get very noisy and loud at times. If [registered manager's name] is here they she will organise staff so that people who need help get it." A relative said, "They [registered manager] are very approachable. I can always chat to them and they listen." Another said, "I would raise any issues straightaway and I would go to the manager to report any abuse." They told us the registered manager had

encouraged them to speak with them if they had any concerns or needed information about how staff cared for their family member.

We asked people and their relatives whether they had opportunities to influence how the service was run. One person said, "We have meetings and the [registered manager] will ask us if we like the food, activities, and what we think of the staff. People will say if they don't like anything." A relative said, "There have been no surveys or questionnaires, we just gave feedback at the end of the care planning meeting." The registered manager told us a satisfaction survey was conducted in August 2016. The results were all positive and no issues to improve the service had been identified. A copy of the results were displayed on the notice board close to the entrance.

Staff told us they were provided with ongoing training and support. A schedule was in place that showed staff's on-going supervision was planned in advance which helped to assure people that they were supported by staff whose knowledge was kept up to date. Regular nurses and care staff meetings were used to share information and discussed ways to improve the quality of the service provided. The meeting minutes showed that staff were reminded about the importance of accurate recording, managing risks and updated on areas that required further improvements.

The provider had a system to support the registered manager to analyse information such as accidents, incidents, complaints to establish any trends or pattern. Records showed people's care needs and risks had been reviewed as a result and where required they were referred to health care professionals for advice and support.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's health, safety and wellbeing was put at risk because their medicines were not stored, managed and administered safely and measures to prevent the risk of choking were not managed correctly. The infection control policies and procedures were not always followed. Equipment used to manage risks and maintain people's safety was not always used correctly or safely. Regulation 12 (1) (2) (b) (e) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not always well managed and lacked effective leadership. The systems to monitor the quality of service were not used effectively and as a result put the health, wellbeing and safety of people who used the service at risk. Regulation 17 (1) (2).