

Oakfield House Retirement Home

Oakfield House

Inspection report

Oakfield House Retirement Home
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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

The inspection took place on 20 December 2017 and was unannounced.

Oakfield House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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.

Oakfield House is registered to accommodate care and support for up to 30 older people. At the time of the inspection there were 24 people living at the service.

There was a registered manager 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 last inspected the service on 16 November 2016, the service was rated requires improvement, there were no breaches of regulations at this inspection. Therefore, the provider was not required to provide an action plan to show what they would do and by when to improve the key questions, safe, effective, responsive and well led to at least good. There were no risk assessments in place for potential risks to people's health and welfare, the principles of the Mental Capacity Act 2005 (MCA) were not always followed. There were no effective audit and quality assurance processes in place. We carried out this inspection to check that improvements had been made. At this inspection we found improvements had not been made and there were two breaches of regulation.

At the last inspection, not all potential risks to people's health and welfare had been assessed. At this inspection, there were some risk assessments in place; these did not contain detailed guidance for staff to follow to mitigate risks. Environmental risk assessments had been completed, however, the fire risk assessment was not up to date and measures to mitigate risk had not been actioned. We contacted Kent Fire and Rescue following the inspection. Not all checks on the environment had been completed in accordance to best practice, for example, water temperatures in people's rooms, to reduce the risk of scalding.

People were not consistently protected against the risk of infection. Accidents and incidents had been recorded and action had been taken on an individual level. However, there was no overall analysis to identify patterns and trends and the action needed to reduce the risk of them happening again.

At our last inspection, there was not a comprehensive and effective audit system in place to identify shortfalls in the service and to drive improvement. At this inspection, the registered manager had not taken action and there had been no improvement. The registered manager had not recorded any audits to monitor the quality of the service and identify areas of improvement within the service.

Quality assurance surveys had been sent to people, relatives, staff and stakeholders such as district nurses, responses had been mainly positive. There had been no analysis of the results and no action had been taken to address any concerns. Staff confirmed that they attended staff meetings and were able to make suggestions. The minutes for these meetings had not been recorded and there was no record that the suggestions had been actioned.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not conspicuously displayed their rating in the service. The registered manager had not attended forums or engaged with outside agencies to keep their knowledge up to date and had been unaware that they needed to display the rating for the service.

Previously, the principles of the MCA had not always been followed. At this inspection, elements of the MCA were still not being followed. People's capacity had been assessed in relation to the decision of where they wanted to live but not in relation to their ability to make day to day decisions. Staff confirmed that best interest decision discussions had taken place when making decisions about people's health and welfare, however, these had not been recorded. Staff sought consent to support people and asked them how they wanted to spend their time or what they wanted to eat and drink.

The registered manager met with people before they moved into the service to check that the staff were able to meet the person's needs. However, the assessments of people's health care needs had not been completed in line with guidance. We recommend that the registered manager finds out about how to assess people's needs in line with current guidance.

Each person had a care plan, but, these did not always contain detailed information about how people liked to be supported. Some information within the care plans was not consistent and there was a risk that staff who did not know the person would not be able to give support in the way the person preferred. People were not consistently asked about their end of life wishes, some people's wishes had been recorded, but there was a risk that people would not receive care as they prefer.

Staff knew how to recognise signs of discrimination and abuse. They were confident that any concerns would be dealt with appropriately. The registered manager had reported incidents to the local safeguarding team when appropriate.

There were sufficient staff on duty, who had been recruited safely. Staff received one to one supervision. The registered manager had not prioritised training and not all staff had received essential training. However, staff had an understanding of their responsibilities and we observed staff support people safely. People received their medicines safely and when they needed them.

People were supported to eat and drink enough to maintain a balanced diet. Staff referred people to specialist health care professionals such as dieticians when required and followed the advice given. People had access to opticians and chiropodists as needed.

People had the opportunity to take part in activities of their choice. People told us they knew how to complain and that the registered manager dealt with any concerns they had. The registered manager had not recorded when they had dealt with concerns. This was an area for improvement.

People told us that staff treated them with kindness and respect. Staff supported people to be as independent as possible. People's religious beliefs were recorded and supported by staff. Visitors were able

to visit whenever they wanted and were always made to feel welcome.

There was an open and transparent culture within the service. The registered manager was known to people living at the service, people and relatives told us that they were approachable. Staff told us they felt supported by the management team and they could speak to them about any concerns they may have.

Oakfield House is a large converted house that has been adapted to meet the needs of people living at the service.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications in an appropriate and timely manner and in line with guidance.

At this inspection two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. You can see what action we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Potential risks to people's health and safety had not been consistently assessed; there was not detailed guidance for staff to follow to keep people safe.

Environmental risks had not been mitigated to keep people safe. Accidents and incidents had not been analysed to identify trends and patterns, to stop them happening again.

People were not consistently protected from the risk of infection.

There were sufficient staff on duty, staff were recruited safely.

Staff knew how to recognise and report abuse.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People's needs were not assessed using best practice guidance.

Staff had not consistently received training appropriate to their role. Staff received supervision to discuss their practice.

The service was not consistently working within the principles of the Mental Capacity Act 2005.

People were supported to eat and drink to maintain a balanced diet.

Staff monitored people's health and referred to specialist health care professionals when needed.

People had access to healthcare services and support.

The building had been adapted to meet people's needs.

Requires Improvement ●

Is the service caring?

Good ●

The service was caring.

People were treated with kindness, respect and compassion.

People were supported to be as independent as possible.

People's privacy and dignity was promoted and respected.

Is the service responsive?

The service was not always responsive.

People received personalised care; however, records did not reflect the care being given.

People were supported to be involved in activities.

People knew how to complain and felt that any concerns would be dealt with immediately.

People were not always asked about their end of life wishes.

Requires Improvement ●

Is the service well-led?

The service was not well led.

There was not a comprehensive and effective audit system in place to identify shortfalls in the service and to drive improvement.

The provider had not displayed their rating as required by law.

People, relatives and staff were asked to give feedback about the service. However, the results had not been analysed to identify any improvements.

Staff confirmed they attended meeting but there were no records kept.

There was an open and transparent culture within the service, people and staff told us the registered manager was approachable.

Requires Improvement ●

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

This inspection took place on 20 December 2017 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury.

During our inspection we spoke with six people living at the service, the provider, registered manager, administrator, head of care, four care staff and the cook. We looked around all areas of the service, we reviewed care plans and associated risk assessments for four people. We looked at staff duty rosters, training records, three recruitment files, health and safety checks for the building, and quality assurance. We observed the care and support people received. We spoke with four relatives visiting the service.

We last inspected the service in October 2016 when the service was rated as 'Requires Improvement' with no breaches of regulation.

Is the service safe?

Our findings

People told us they felt safe living at the service. One person told us, "I definitely feel safe otherwise I would not stop here." Another person told us, "I feel safe here." Despite these positive comments, we found that the people were not always kept safe at the service.

At the last inspection, there was no formal assessment and documentation of potential risks to people's health and welfare. Staff did not have detailed guidance to follow to keep people safe. At this inspection, each person had a 'Resident Risk Assessment Update' document in place. The document was one page, it contained brief information about the person.

Potential risks to people's health and welfare had not been consistently assessed and there was no guidance for staff to follow to mitigate risks. For example, it was identified that some people may not ring their bell at night when they are likely to fall. There was no guidance for staff to follow to reduce the risk of people falling. In another example, it had been identified that people were not always aware of their limitations and abilities in regards to their mobility. The only guidance for staff was that people would need assistance when going outside, but not what assistance they should give to keep people safe.

Some people were living with diabetes; district nurses were responsible for administering the insulin. However, staff were responsible for monitoring people's health and recognising when people required medical assistance. There was no detailed guidance about the signs and symptoms staff should look for when people's diabetes became unstable. The care plan stated that people's blood sugars could drop but there were no guidelines as to what blood sugar levels were high or low. There was guidance about what staff should do if people's blood sugar levels were low but not if the levels were high.

Staff were able to tell us how they supported people to keep them safe. Staff knew how to support people with diabetes, they told us the signs and symptoms of low and high blood sugar and what they would do if this happened. We observed people being supported safely with their mobility during the inspection.

Checks on the environment had not been consistently completed, which put people at risk. During the inspection, we observed a large number of bedroom doors that were wedged open, and would not close in the event of the fire alarm being activated. The registered manager told us that this had been agreed by the fire service and was contained in the fire risk assessment. The fire risk assessment had not been updated since 2013 and stated that the doors needed to be fitted with an approved hold open device. This safety feature was not in place, and there was no guidance for staff about what action to take to close the doors if the fire alarm was activated. We informed Kent Fire and Rescue of our concerns following the inspection.

Water temperatures in people's bedrooms had not been recorded to check the temperatures were safe, to reduce the risk of scalding. The recommended water temperature to reduce the risk of scalding is below 44 degrees. The registered manager told us that the boiler had a thermostatic valve in place to keep the water at the required temperature. They told us that the water temperature in the kitchen was recorded to check that the thermostat was working. The records showed that the temperature of water in the kitchen was 51

degrees. The registered manager had not checked that the water temperature in people's rooms was 44 degrees or below. Staff had recorded the water temperatures when people had baths and this had been below 44 degrees. The registered manager told us that the service did not have any water tanks, and therefore did not need to be checked for legionella. Inspectors had seen water tanks in the service, and reported this to the registered manager who did then agree that there were water tanks and that a legionella test would be needed.

There had been a health and safety audit completed by an outside consultant in February 2017, the audit had identified the shortfalls found at this inspection. The registered manager had not taken action to rectify the shortfalls.

People had not been consistently protected against the risk of infection. Potential risks to people had not been identified and managed to reduce the risk of infection. In each bath there was a non-slip mat, these were used by each person. There was no record of if and when these mats had been cleaned or guidance about how to clean them. The mats that people used to stand on when they got out of the bath were not for individual use, there was no information about when these should or had been changed and washed.

The provider had failed to do all that is reasonably practical to assess and mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents had been recorded. The registered manager and head of care had taken action to refer individuals to professionals such as physiotherapists when needed and this was recorded in people's care records. However, there was no formal recording and analysis of accidents and incidents to identify trends and patterns. The registered manager told us that the service used incidents to learn from, however, there were no records kept and the registered manager did not have an example.

People's medicines were administered safely by staff who had received training, been assessed as competent and understood their roles and responsibilities. Medicines were, on the whole, managed safely. However, the medicines room was used one day each week as the hairdressing salon. This was observed during the inspection. The medicine trolleys were kept in another room during this time. The room was not locked and the medicine trolleys were not secured to the wall, as required by best practice. This was an area for improvement.

We observed people receiving their medicines safely. There were appropriate systems in place for ordering, administering and disposing of medicines in line with best practice. However, there were prescription creams in the bathroom that did not have a label with instructions or who the cream was prescribed for. There was a risk that these creams would be used for people that had not been prescribed the creams. The head of care told us that the creams would be removed from the bathrooms. We will check this on our next inspection.

Some people were prescribed medicines on an 'as and when' basis. There were guidelines in place for staff to follow about when to give medicines. Medicine administration charts had been completed accurately and medicine levels were correct.

There were sufficient staff on duty. Staff told us they thought there were enough staff. One member of staff started at 7am to support people who wanted to get up early. The service did not use agency staff, any sickness or annual leave was covered by the staff team. The registered manager and head of care used their knowledge of the people living at the service to decide staffing levels. The staff rotas showed that staffing levels were consistent. People told us that they thought there were enough staff. One person told us, "There

is enough staff."

Staff were recruited safely. Recruitment checks were completed to make sure staff were honest, reliable and trustworthy to work with people. These included a full employment history and written references. Each person had proof of identity. Disclosure and Barring Service (DBS) criminal records checks were completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

People were protected from the risks of abuse and discrimination. The registered manager referred to the local safeguarding team when required. Staff knew what to do if they suspected incidents of abuse. Staff told us that they were confident that any concerns raised would be dealt with appropriately by the registered manager. Staff understood how to support people in line with their choices and preferences, and for people to be treated equally. Staff understood their responsibilities to challenge colleagues and people who discriminated against people.

People told us they were happy with the standard of cleaning. There were sufficient domestic staff to ensure standards were maintained, including laundry staff. Domestic staff followed cleaning schedules to ensure that all areas of the service were cleaned regularly. Staff wore protective clothing such as gloves and aprons when required. There were different coloured gloves and aprons for different tasks, for example, staff wore blue gloves when serving food.

Is the service effective?

Our findings

People told us that they were supported to access their GP and other healthcare professionals when needed. One person told us, "The staff call the GP when I am unwell."

Before coming to live at the service, the registered manager would meet with people and their relatives to complete an assessment and to check that the staff had the skills and knowledge to support the person. The assessment covered all aspects of people's physical and mental health, and any cultural preferences the person may have. The assessment we reviewed, contained limited information about people's needs. For example, it had been written the person had vascular dementia, but there were no details as to how this affected the person in their day to day life.

The assessment of people's needs had not been completed following guidance. The National Institute of Clinical Excellence (NICE), states that people's potential health needs should be assessed using a recognised tool. People's care plans and assessments did not contain any assessment tools and the registered manager told us these had not been completed. However, when people needed specialist equipment such as a pressure relieving mattress these were in place.

We recommend that the registered manager finds out about how to assess people's needs in line with current guidance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as much 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 possible.

People can only be deprived of their liberty so that can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked to make sure the service was working within the principles of the MCA.

At the last inspection, we found that staff were aware of the MCA, but their knowledge had not been embedded as some people's mental capacity had not been accurately determined. At this inspection, people's capacity had been assessed on arrival at the service but this had not been updated. The capacity assessment had been used to decide if DoLS application was needed.

There were no recorded assessments of people's capacity to make specific decisions. On the risk assessment update people's cognitive state was reviewed. On one person's the review stated that the person's ability to make decisions varied from day to day and on another the person had moderate confusion. On all the documents the registered manager had written, 'In my opinion, the (person) is aware of the dangers and therefore competent enough to have toilet cleaner left in their room and to have window

restrictors removed.' There was no document to show how the registered manager had reached this decision and who had been consulted including the person. The documentation and assessment was not individual as the use of 'his and her' was not correct in two of the documents. The registered manager confirmed that they had not consulted the person.

There were no records to show that best interest decisions discussions had been held to make decisions if people were unable to make themselves. Staff understood that when people could not make decisions for themselves, people who know them well should be consulted. The head of care confirmed that when decisions needed to be made families and healthcare professionals had been consulted but this had not been recorded. People's records showed if someone had power of attorney, but did not say if this was for financial decisions or health and welfare.

The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user in respect of decisions taken in relation to the care and treatment provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, we observed staff asking people what they wanted to and what they wanted to eat and drink. People told us that staff respected decisions they made.

At the last inspection, staff had not received training updates, to ensure that their practice met best practice guidelines. At this inspection, some improvements had been made but further improvements were required. Records showed that staff had either completed training updates or were due to complete updates in the majority of the essential training. However, only one member of staff had completed safeguarding training in the past year and all other staff including new staff either had not received training or was out of date. The registered manager had not prioritised the training that was required. Some staff had received training on healthcare conditions such as diabetes and dementia, but there were no plans for additional staff to attend training in these subjects. Staff were able to explain to us how they cared for someone with diabetes and their responsibilities to report abuse. This was an area for improvement.

New staff completed an induction, this included working with experienced staff to learn people's choices and preferences. Staff completed the Care Certificate as part of their induction, which is an identified set of standards that social care workers work through based on their competency.

Staff told us that the head of care observed them administering medicines to ensure they were competent. The head of care confirmed that they observed medicines administration and worked with staff on a day to day basis. However, these observations had not been recorded, including if any action had been taken if staff practice did not meet the required standard. This was an area for improvement.

Staff received one to one supervision from the registered manager to discuss their practice. Staff told us that they felt supported by the registered manager and head of care that any concerns they had would be dealt with appropriately.

People were supported to eat and drink to maintain a balanced diet. People told us that they enjoyed the food, one person told us, "The food is good and we have a choice." Another person told us, "The food is excellent."

People had a choice of meals and the menu was available in the dining room. The food was served at the table and people were able to help themselves to the portions they wanted. Staff supported people if needed and encouraged people to eat. People were able to choose where they ate their meal, either in the

dining room or their own room. The cook knew people's likes and dislikes and if people required a special diet.

People were supported to be as healthy as possible. Staff monitored people's physical and mental health and took prompt action if there were any changes. People's weight was monitored and people were referred to the dietician when they lost weight. The guidance from healthcare professionals was followed by staff. People received regular visits from the chiropodist and optician. People told us they were supported to visit their own dentist when required.

People were referred to the GP and district nurse, when changes in people's health changed. Staff supported people to make appointments with their GP and attend the surgery. People were encouraged to be involved in decisions about their care whenever possible.

Oakfield House is a large converted house with a garden. The building was adapted to meet people's needs including a passenger lift. People were able to move freely around the building. The building was clean and tidy, maintenance was completed when necessary.

Is the service caring?

Our findings

People told us that staff treated them with kindness and respect. One person told us, "They always knock and wait before entering my room, they are a lovely crowd."

Staff knew people well; most of the staff had worked at the service for many years. Staff told us, "We treat people as family." Staff spoke with people in a kind and compassionate way; strong relationships had developed with people and relatives. Staff knew about people's backgrounds and people who were important to them, staff chatted to people about the things they enjoyed.

Staff responded to people when they became anxious or upset, giving them reassurance. During the inspection, one person became anxious about meeting new people, staff spent time with them until they were reassured and happy. Staff approached people in the way they preferred and called them by their preferred name. For example, staff greeted one person in a loud cheerful voice and the person responded in the same way, with another person, they spoke quietly and touched their arm.

Staff encouraged people to be as independent as possible. For example, people were encouraged to dish up their own meals, and were supported to attend the GP surgery. Staff supported people to walk with appropriate aids, offering encouragement. During the inspection, one person felt they were taking a long time to walk to their room and said this to the member of staff. Staff told them, "It is fine, I am in no hurry as long as you are alright." The person smiled and carried on with their journey.

People's privacy and dignity was respected. People told us and we observed, staff knocking on people's doors and waiting to be asked in. Staff told us how they promoted people's dignity by making sure they were covered when they were attending to their personal care. Staff kept people's personal and confidential information about them and their needs secure to protect their privacy.

People were encouraged to personalise their rooms their rooms with their own possessions such as photos and ornaments. People were encouraged to maintain and develop relationships with people that mattered to them. Visitors were welcome at any time, throughout the inspection, relatives and friends visited people. Relatives told us they were always made to feel welcome by staff.

People's religious beliefs were discussed and recorded. People were supported to maintain their beliefs. One person told us, "The vicar comes in to me every two or three weeks." People had the opportunity to attend a meeting every Monday to discuss religious matters and pray. The registered manager told us that they support different beliefs, ensuring that representatives of the faith are contacted. For example, previously a Rabbi visited a person who followed the Jewish faith.

Some people were unable to express their views about their care, so staff ensured that decisions were made involving people who were important to them. Some people had nominated a person to represent them, however, some people had not. When this was the case, staff knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs

and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or speaking on their behalf.

Is the service responsive?

Our findings

People told us that they received care and support in the way they preferred. One person told us, "The staff know what I like."

Each person had a care plan that contained a profile of their needs, choices and preferences. There was information about their past life and family that were important to them. On admission the registered manager completed a care sheet with a brief outline of people's health conditions, aims of the plan and instructions to staff. These documents did not have the person's name and there was no space for it to be added, there was a risk that the documents could be put into the wrong file.

Key workers completed an assessment of people's needs for the day and night; a keyworker is a member of staff who takes a lead role in their care. These were reviewed and updated regularly. The information contained in these assessments was not detailed as to people's choices, preferences and how to provide support to people. Some people required two staff to assist them to wash and dress. The guidance in these care plans was the same; there was no additional detail about how to provide support unique to that person.

The information about the care and support people needed was not consistent throughout the documentation. Records completed in October 2017 for one person stated that they needed the assistance of one carer to wash and dress whereas another record stated the person was independent. Staff told us that if the person felt well they were independent with most of their care, but at times the person requested assistance of a member of staff. However, there was a risk that new staff who did not know people would not give support as people preferred due to the lack of detail in care plans.

Care plans did not consistently contain information about people's end of life wishes. Some people's wishes had been recorded, for example, there was a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place, when people had requested it. Some staff had received training in end of life care and were able to tell us about the support they would give people. Staff told us that they would work with the GP and district nurse to support the person to be as comfortable as possible.

The provider had failed to maintain an accurate record for each service user. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Completed records and updates had not been removed from people's care plans. Care plans contained records that dated back five years, which meant it was confusing for anyone looking at the care plan to find the current information. The registered manager told us they hadn't removed the information so that staff were able to find information when asked. They agreed that they would look at the care plans and remove any documents that were not relevant. This had little impact on the support people received as staff knew people well, and people told us they received the support they needed.

Whilst walking around the building, a number of shampoo bottles and soap were seen in the bathrooms.

The head of care did not know who the toiletries belonged to and confirmed that they could be used whilst supporting different people. There was a risk that people's own preference and choice of toiletries were not being used. The head of care told us the toiletries would be removed and staff reminded to use people's own toiletries. We will check this at the next inspection.

People were encouraged to follow their interests; people went to the library and for walks in the village. Outside entertainers came to the service including musicians. People were able to join in fitness classes, bingo and art classes. There was a full programme of activities over the Christmas period, during the inspection, a choir came and sang carols that people enjoyed.

People told us that they would speak to the registered manager if they had any complaints. People were given information about how to complain, this was displayed on notice boards. However, it was not available in different accessible formats. This was an area for improvement.

There had been no written complaints since the last inspection. The registered manager told us that they responded promptly to any 'niggles' that people or relatives brought to them. During the inspection, the registered manager responded to a concern from a relative immediately. However, the registered manager had not recorded when they had received verbal complaints, how they had been dealt with and the outcome. This was an area for improvement.

Is the service well-led?

Our findings

At the last inspection, there was not a comprehensive and effective audit system in place to identify shortfalls in the service and to drive improvement. At this inspection, the registered manager had not taken action and there had been no improvement.

The registered manager had not recorded that they had completed any audits on the quality of the service, including medicines, care plans, infection control and recruitment. A health and safety audit was completed by an outside consultant, but the recommendations had not been actioned. The fire risk assessment was not up to date and the recommendations to keep people safe had not been followed. The registered manager had not completed checks on the environment in line with best practice, such as water temperatures and legionella tests.

The registered manager had not assessed risks to people's health and welfare in line with guidance. Risk assessments did not have detailed guidance for staff to follow to keep people safe. Care plans were not accurate and did not reflect the care and support people received. There was a risk that if staff did not know people, they would not receive the support they needed.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not conspicuously displayed their rating in the service. The provider does not have a website. The registered manager told us that they were not aware that the rating needed to be displayed. During the inspection, the registered manager had displayed the rating given at the previous inspection.

The provider did not have systems or processes in place to assess, monitor and improve the quality and safety of the service. The provider had failed to assess and monitor risks and maintain accurate records for each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) 2014.

The registered manager had not kept up to date with current legislation and regulations. The registered manager did not have contact with provider groups or forums such as Skills for Care or local forums organised by specialist care home nurses. We discussed with the registered manager about the support available for registered managers, they told us they would contact the specialist care home nurses.

Quality assurance surveys had been sent to people, relatives, staff and stakeholders such as district nurses. The feedback had been mainly positive but there had been no analysis of the responses and action plan formulated for any suggestions made. Staff confirmed they attended regular staff meetings; the minutes of these meetings had not been recorded. Staff told us that they were able to make suggestions and these were implemented when possible. Staff were not able to give examples and with no records of the suggestions or the actions taken, this could not be confirmed.

There was an open and transparent culture within the service. We discussed with the registered manager and staff about their vision for the service. They told us that they wanted the service to be a home for people and for them to feel comfortable. The registered manager told us that they spent most of their time with people making sure they were happy. The relatives and people we spoke to were positive about their experience and how lovely the service was.

The registered manager and head of care had day to day oversight of the service. People told us that the management team were approachable and they were able to discuss anything with them. One person told us, "We feel able to speak to the manager." Another person told us, "We have a good response to what we discuss." During the inspection, people appeared to be comfortable with the registered manager; people were laughing and chatting to them. Relatives came into the office and spoke to the registered manager about their relatives support. There was a staff communication book for staff to leave messages, so that all staff knew what had happened within the service. Staff attended a verbal handover at the beginning of each shift, to keep up to date with people's needs.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications in an appropriate and timely manner and in line with guidance.

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 The provider had failed to do all that is reasonably practical to assess and mitigate risks.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems or processes in place to assess, monitor and improve the quality and safety of the service. The provider had failed to assess and monitor risks and maintain accurate records for each service user. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user in respect of decisions taken in relation to the care and treatment provided.