Tameng Care Limited

St Catherine's Care Home

Inspection report

5 Queen Street
Horwich
Bolton
Lancashire
BL6 5QU

Tel: 01204668740
Website: www.fshc.co.uk

Date of inspection visit:
29 August 2018

Date of publication:
20 November 2018

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 unannounced inspection took place on 29 August 2018.

St Catherine's Care Home Horwich, Bolton is a purpose built two storey care home. The home is close to Horwich town centre and close to a bus route and the motorway network. The home provides nursing care or personal care for 30 people and cares for 30 people living with dementia in a separate area of the home called Pike View. On the day of the inspection there were 58 people living at the home.

St Catherine's is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This last inspection took place 7 December 2017 and the overall rating was Requires Improvement. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to Person centred care, dignity and respect, safe care and treatment, medication, governance and staffing.

At the inspection on the 29 August 2018 we found that some of the breaches had been met. However, we found continued breaches in medication, person centred care and governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The service had a registered manager in place. 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.

There was an appropriate safeguarding policy and procedure in place, staff had undertaken safeguarding training and had a good understanding of how to report any concerns.

Staff recruitment was robust and staffing levels were good on the day of the inspection. There was a good induction programme for new staff and training was on-going.

There had been improvements to the overall cleanliness of the building. There was a rolling programme of refurbishment following the installation of a new heating system. The hot water in some of the bathrooms was extremely hot and could be potentially dangerous to people. Medicines were not safely managed.

Health and safety certificates were in place and general risk assessments and individual risk assessments had been completed.

People told us the food was 'awful' and we found choices were limited. This was due to the catering contractors that the home was instructed they had to use. The mealtime experience could have been improved. People were waiting for long periods of time to receive assistance with their meals.

People had mixed views about the care provided at the home, some people thought that care was task orientated and staff had not enough time to spend with people who used the service. We saw visitors were welcome at any time.

There were up to date policies on privacy, whistleblowing, medication and confidentiality. Residents' and relatives' meetings were held; however, these were poorly attended. The registered manager held a 'drop in' meeting so people could speak with her if they wished.

Some of the care files we looked at did not always show evidence that collaborative needs had been assessed and there was limited evidence to suggest people's preferences had been addressed.

There was an up to date complaints procedure in the reception area and this was also in the information provided to people living at the home and their relatives.

The service was working within the legal requires of the Mental Capacity Act 2005 (MCA) and the deprivation of Liberty Safeguards (DoLS).

People we spoke with said the registered manager was approachable. We saw evidence of staff supervisions and appraisals. Staff meetings took place; however, these were poorly attended.

The service worked in partnership with other agencies and were involved with the Bolton Care Homes Excellence programme.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There was an appropriate safeguarding policy in place, staff had undertaken safeguarding training and had a good understanding of the issues and how to report any concerns.

Medicines were not safely managed. The hot water temperatures were unsafe in some areas of the home.

Staff recruitment was robust and staffing levels were satisfactory on the day of the inspection.

The cleanliness of the home had improved.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs).

There were concerns raised about the quality of the food. People were not receiving a healthy and nutritious diet.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring. We saw good staff interactions with people.

We saw that visitors were made welcome at any time.

There were up to date polices on privacy and dignity and confidentiality

Is the service responsive?

Requires Improvement

The home was not consistently responsive to people's needs.

Consideration needed to be given to providing meaningful activities and stimulation.

Some of the care files we looked at did not always show evidence that collaborative needs had been assessed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People we spoke with said the registered manager was approachable. We saw evidence of staff supervisions.

Residents' and relatives' meetings were held periodically. Staff meetings were held; however, these were poorly attended.

There was a system in place for monitoring the quality of the service provided. However, some of the audits had failed to identify some important issues.

St Catherine's 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 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 29 August 2018. The inspection team consisted of two adult social care inspectors and a pharmacist. We were accompanied by a Specialist Advisor (SPA) who was a registered nurse and two experts by experience. An expert by experience is a person who had had experience of using or caring for someone who used this type of service. Both experts by experience had personal experience with older people and people living with dementia.

Prior to the inspection we looked at the information we had received about the service. This included notifications, safeguarding concerns and whistleblowing information. The notifications we had recently received indicated a number of medication errors.

We contacted the local authority commission team, the local authority safeguarding team, the Clinical Commissioning Group (CCG), the Community Infection Control team. Concerns were raised by these agencies about how St Catherine's was currently operating. We also contacted Healthwatch Bolton. Healthwatch is an independent consumer champion for health and social care.

During the inspection we spoke with the registered manager, the resident specialist advisor, the two nurses on duty and seven staff, a visiting health care professional and the kitchen staff. We also spoke with four people who used the service and six relatives.

We looked at 11 care records, four staff personnel files, 10 medication records, training records, staff supervisions, meeting minutes and audits.

Requires Improvement

Is the service safe?

Our findings

On arrival at the home we found the front door was locked. This meant that people were kept safe from unwanted people entering the home. People had to wait for staff to let them and were asked to sign the visitors' book on arrival. This was so staff knew who was in the building in the event of an emergency.

Family members we spoke with felt their relatives were safe. Comments included, "[Relative] likes it here, we've have no problems here, staff are great with [name]". One person told us, "The staff make me feel safe", another said, "The staff are lovely very kind". People also told us they felt their property was safe and secure. There was information in the foyer about the home and the services available to people.

There was an appropriate, up to date safeguarding policy in place for staff to refer to if required. This was reviewed every three years. There was a safeguarding log and any concerns were filed and actions recorded and lessons learned. Staff had undertaken safeguarding training and demonstrated a good understanding of the issues and how to report any concerns.

Staff recruitment was robust at the home. All the necessary information was included in the four staff files we looked at. This comprised of an application form, references, proof of identity, terms and conditions of employment, an interview assessment and a Disclosure and Barring Service check (DBS). DBS checks help ensure that staff are suitable to work with vulnerable people and informs the provider of any criminal convictions against the applicant.

On the day of the inspection there were sufficient staff on duty. However, the size of the home and the layout of units made it difficult at times to locate staff. We observed in Pike View that people in the small lounge areas were often left alone for long periods of time. In another part of the home we noted from their care records that one person required three to four staff when personal care was required. This meant at times all the staff on the unit could be attending to one person leaving the rest of the unit without a staff presence.

Family members commented on how busy the staff were, although they were satisfied that this did not impact on their relatives in that they were still attended to in a timely manner when they needed help. The family members we spoke to were comfortable about approaching staff if they had any queries or concerns.

At our last inspection there was a breach in the regulations regarding infection control. At the inspection of 29 August 2018, we found that infection control had improved. The infection control team revisited the home on 25 April 2018. From their observations there were still areas that required attention. The infection control team will continue to monitor the service.

Family members were happy with levels of cleanliness. One family member told us: "At first, I used to check the room every day I came but I've stopped doing that now because I feel there is no need". Another family member felt levels of cleanliness had "gone down over the last two years", although there had been signs of improvement recently. One family member had complained about the smell in their relative's room and had been told that the carpet would be replaced. Another family member had a similar problem previously,

which was resolved when the carpet was replaced with new flooring, but this had taken some time to achieve.

The care records we looked at showed that risks to people's health and wellbeing had been identified, such as poor nutrition, weight loss, falls, choking, the risk of pressure wounds and medication. However, we found that the care records were not always adhered to.

At our last inspection we saw that medicines were not handled safely. At this inspection a pharmacist, medicines inspector, looked at medicines and records about medicines for 29 people to make sure that medicines were managed safely and people's health was not put at risk. We found some minor improvements had been made but we found that overall medicines management was unsafe.

The home had improved the application, storage and recording of creams. The home had also ensured that the oxygen cylinder was now stored safely. At the last inspection we found medicines were out of date. At this inspection we saw that there were no out of date medicines in the home except for one bottle of morphine solution, which was not being used but was one day out of date, there was another unopened bottle of morphine in stock which was in date.

Prior to our inspection we had received notifications from the home about medicines errors that had been made. Five of these notifications told us that people had not been given one of their medicines on or around mid-August 2018. The doctors had been informed and they advised people would not come to any harm, their next of kin and safeguarding were also informed. During this inspection we checked the stock levels of 30 medicines for 10 people. We found that all 10 people had not been given one or more of their medicines as prescribed. We found only 10 medicines had been given as prescribed and could be accounted for. Twelve medicines could not be fully accounted for because there were fewer tablets in stock than expected and we found that eight medicines had been signed for and not given because there was more stock than expected. The home's Resident Experience Specialist told us that she had concerns that medicines would not be given properly because the tablets were now all supplied in traditional boxes and bottles rather than in blister packs. A stock count was in place for each medicine, and the remaining tablets should have been counted and quantity of stock recorded after each dose. However, the managers had not been made aware that nurses or the care home assistant practitioners had found any discrepancies. This means that people's health had been placed at risk of harm because they had not been given their medicines properly.

Three people had run out of one of their medicines. One person's medicine used to treat symptoms of Parkinson's disease had been out of stock for seven days and it was still out of stock on the day of the inspection. Another person had not been able to have their medicine for acid reflux/heartburn for five days because it was out of stock.

We looked at the information, protocols, available for staff to follow when administering medicines which were prescribed "when required" or with a choice of dose for nine people. We found that there was no information recorded to guide staff when to select the upper or lower dose. We saw that there were no protocols for medicines prescribed "when required" for eight people. One person was prescribed a medicine for seizures and there was no protocol to support the safe administration of this medicine. If protocols are not available, people may not be given medicines prescribed in this was safely or consistently.

We looked at the information available to ensure that seven people could be given their medicines safely when they were given "covertly" or hidden in their food or drinks. Information had been obtained from a pharmacist to explain how each medicine can be disguised for two people. However, there was no information for the other five people which meant they may not be given their medicines safely. We also saw

that there was no information recorded to explain to staff administering medicines the foods and drinks the medicines were safe to hidden in.

Twenty people with swallowing difficulties, were prescribed thickeners to be added to their fluids to help prevent them from choking. We talked to care staff who prepared drinks for people and all the carers knew that there was information recorded for agency nurses on their hand over sheets about how thick to make each person's drinks. Carers told us they did not refer to any records to check how thick to make peoples drinks because "they knew everyone really well" and "they had been there a long time". One carer told us they just followed the directions printed on the dispensing label on the tin. We saw that the information for one person on the tin stated that the drinks should be made to syrup thickness but the handover sheet said the should be given custard thick fluids. The handover sheet that was given to us during the inspection was undated. If carers do not refer to up to date information each time they make people's drinks they may not thicken them correctly which would place people at risk of aspiration or choking. As at the last inspection we found that carers who made the drinks did not make records about how thick they made each person's drinks, so they could not evidence that they had made drinks the correct thickness.

The medicine's rounds on the morning of the inspection took a long time. The round was completed on Pike View at 10:30am and lunch time medicine's round commenced at 12:30pm, just two hours later. On the nursing unit the round finished after 11am and staff told me that they could start giving lunch time medicines after 2pm. On this unit we saw lunchtime medicines were still being given after 3pm. This meant that there would be an impact on the tea and bedtime rounds which may mean people had their medicines too close together or had to miss medicines as they would be asleep before they could safely be given the next dose of medicines. We saw people were given Paracetamol regularly but no time of doses was recorded which meant it was not possible to tell when it was safe to give the next dose because there must be a minimum of four hours between doses. However, we did see that when people needed to be given medicines at specific times, such as medicines to relieve the symptoms of Parkinson's, they were given at the times they were prescribed.

Medicines were stored securely in a locked medicines room. However, the room was locked by means of a key pad rather than by keys held by the staff with authority to manage medicines. The use of a keypad could give unauthorised people access to medicines. Waste medicines were kept in an unlocked cupboard which means that these medicines could be misused. Medicines stored in the fridge were often stored at temperatures higher than recommended by the manufacturers. During the inspection the fridge alarm, indicating it was too hot, went off four times. Medicines stored at the wrong temperature could affect the way they work.

We found this was a continued breach of Regulation 12(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that medicines were not administered safely.

There was personal emergency evacuation plan (PEEPS) in place for each individual at the home. These were in each care record and in the foyer. These were updated when changes occurred and outlined the level of assistance each person would require in the event of an emergency.
We looked at health and safety records. Certificates were up to date for electrical testing, gas safety and portable appliance testing (PAT). There had been a thorough examination of the passenger lifts and moving and handling equipment had been tested and maintained to an acceptable standard. There was a fire risk assessment in place and fire alarms and emergency lighting had been tested regularly and the records were up to date.

We saw that water temperatures were tested monthly and temperatures were recorded. However, on testing

one of the hand basins in one of the bathrooms in Pike View we found the water was too hot to keep your hands under. We asked the registered manager to check that all water was running at the correct temperature and ensure the thermostatic values were in working order to prevent people from scalding themselves. We also saw that in the upstairs bathroom, the file for recording the temperature for the hot water before people had a bath had not been completed since May 2018.

Accidents and incidents were recorded and monitored for each person and an overview which provided an analysis for patterns and trends was in place to help prevent reoccurrences.

Requires Improvement

Is the service effective?

Our findings

We saw that staff completed an induction on commencing work at the service. This included essential training in areas such as medication, fire safety, infection control, moving and handling and dementia awareness. One carer told us, "I have done all mandatory training. I have also done Speech and Language Therapy (SALT) training, pressure sores, catheter care and creams application". People we spoke with told us they thought staff were well trained. One said, "Yes they know how to care for me". Another said," Yes they help you with things they seem to have been here a long time and they are experienced". One relative told us they were contacted in a timely manner about any change in their relative's health conditions or when the GP had been called.

Staff supervisions were ongoing. Supervision meetings are one to one discussions where the member of staff can discuss any further training and development that they may wish to undertake.

Care records we looked at included a range of information relating to health and wellbeing. However, we found that these were not always being adhered to. For example, we saw that for one person who had two pressure wounds the waterlow score had been completed and the care plan demonstrated wound care and pressure relief was needed however, the needs and outcomes was dated 2017. The care plan did not reflect any changes despite these being significant in terms of deterioration since the care plan had been written. For this person there was evidence to show input from the tissue viability service who recommended a dressing change plan of every four days. There was evidence to demonstrate this was not being adhered to with gaps of up to seven days between dressing changes. Dressings to the left heel were also in the care plan stating the dressings needed to be changed twice weekly. However, the records showed a gap of nine days. In terms of pain relief, the care plan from the tissue viability nurse suggested pain relief as already prescribed. On corroboration with the CQC pharmacist on the day of the inspection it appeared that no pain relief was given or offered.

For another person who received their food through a tube into their stomach we saw the care plan was comprehensive in terms of food consistency, cleaning and infection control. The care plan was reflective of requirements for flushing before and after feeds and between medication doses. We were supplied with the diet and fluids charts which were being recorded daily. However, there were omissions in the recordings. We were told that appropriate mouth care was given to this person, however, there was no care plan for this or evidence that this had been reviewed.

We looked at the care record for a person who was type two diabetic. The notes did not show consistency and varied in terms of dietary needs. On one occasion it referred to a diabetic diet, another reference said normal diet with a diabetic pudding. We noted variance in relation to minimum and maximum blood sugar levels ranging between four to six which raised the question at what point would staff consider this person at risk.

For one person there was no care plan despite this person being at the home for seven days. We discussed this with the registered manager who told us, "[Person] had only been here a short while. We did not have

time to do a care plan". We also saw that this person had been given medicines covertly (hidden) on 17 August 2018. However, it was only on the 20 August 2018 that the GP had agreed for medicines to be given covertly in this person's best interests.

In another care record we looked at we saw there was a hospital passport. A hospital passport goes with the person should they need to go to hospital. It informs the hospital staff of important information including names, date of birth, allergies, medication and emergency contact details.
We saw that the hospital passport had the name of the previous care home where this person used to live. This meant that the ambulance staff could have returned this person to the wrong home.

We found this to be a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to a specific care plans and incomplete records.

We asked the registered manager to tell us how, in the event of a person being transferred to hospital, information about the person was passed to the receiving service. We were told about the 'Red Bag' that was sent with the person. The Red Bag should contain the person's care and medication records, their medication and their personal items.

The Red Bag Initiative was rolled out to all nursing and care homes across Bolton NHS Foundation Trust. We were told the aim of the initiative was to improve the experience of people when they were admitted to hospital and reduce their length of stay by speeding up the discharge process and improving communication between hospitals and nursing homes.

The home had received a five-star food hygiene rating, which was good. We asked about what people thought about the food. Comments were overwhelmingly poor. The food was described as 'awful' and 'vile'. People who had lived at the home for some time told us that since this company had taken over the food had gone downhill. On the day of the inspection we saw that the pureed diet for twenty people was pureed bacon, cheese and onion with a crumble topping. The inspectors tasted the food and found this to be colourless and a tasteless plate of extremely thick food which was difficult to swallow. We discussed with the kitchen staff and the management team about the pureed diet offered. We were told that all the food on the menus could be pureed. This included sandwiches, crumpets and a buffet. We questioned how this could be palatable and suitable for people with swallowing problems.

Staff and relatives spoken with all agreed that the food was not up to standard. The home's Resident Experience Specialist showed us an email trail sent to the company about the food.

We looked at the menus, these had been poorly planned with often two meat dishes available for the lunch time meals instead of a meat free dish. Some of the food was not age appropriate for example a 'fish finger butty'. We were also told that food was not fortified with butter and cream but with a supplement powder. We asked if there was a good supply of fresh fruit and were told no but occasionally they were some bananas. We were told that the biscuits, chocolate and crisps were no longer ordered.

We also noted that from the records we looked at that some people had lost weight. There was a high usage of supplement drinks. This meant that some people may not be having a nutritional, healthy and well-balanced diet. We also noted that the food and fluid charts required more detail about the about how much food and drink people had actually had. For example, it was recorded 'eaten all' but there was no indication of actual amounts.

We found this to be a breach of Regulation 14 of the Health and Social Care 2008 (Regulated Activities)

Regulations 2014.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care home and hospitals is called the Deprivation of Liberty Safeguards (DoLs). We saw DoLS paperwork within care files as required.

We saw in the care records we looked at there was good information about consent, capacity and best interest meetings. Staff spoken with had good understanding of MCA and DoLS and could tell us who was subject to DoLS and what this meant in practical terms. There was a DoLS matrix in place which included the date when the DoLS had been applied for, date of when it was authorised, the expiry date and when CQC had been notified.

The design and layout of the building allowed people to move freely around the home. Corridors were wide enough for people to use walking aids and wheelchairs. People had access to outside garden areas which were equipped with tables and chairs. We saw that there was appropriate signage to help people orientate around the home. The home was well lit with both natural and electric lighting. We saw that some rooms were being decorated as the home had recently had a new heating system and radiators fitted.

Good

Is the service caring?

Our findings

We asked people about the care they received and were told the staff were kind and caring. Comments included; "Yes they are, some more than others". Another said, "Yes to a certain extent, they are only human and sometimes they can be in a bad mood". A third person said, "Yes, they always say good morning, they are always pleasant when they do something for you". One relative told us, "It's not that they are not caring there is just not enough of them to spend that extra bit of time. I worry what happens when I am not here, for example will they forget to feed [name] and make sure [name] is turned regularly".

Staff spoken with demonstrated a good knowledge of the people they were caring for. They knew their likes and dislikes and preferences.

We spoke with relatives in Pike View who felt the staff were good and proficient at getting to know people in their care and their relatives. One family member said, "They [staff] are really good, can't fault them". Another said, "They [staff] are really good, very friendly". We observed that staff interactions tended to be mainly task associated and not focused on individuals. People were living with advanced dementia and required a high level of care and several could not communicate other than by facial expression or eye movement. People smiled when staff approached them and they seemed comfortable with the staff.

We saw that people looked well cared for and were appropriately dressed. People who were being cared for in bed looked warm and comfortable.

We asked the care staff how people who could not get to the bathroom or shower were provided with personal care. We were told that those people would be given a bed bath. However, we noted that there were no washbowls in rooms and staff explained they just used the sink in the bedroom and a cloth. Staff said two people had washbowls but agreed that they should be available in all rooms. Following our inspection, we have been informed that 60 bowls have now been ordered.

We asked people did staff treat them with dignity and respect. People told us, "They [staff] make sure I am in private when any care is done". Another said, "Yes, everything is private and we are not embarrassed". We noted in some bedrooms there was confidential information on the wardrobe doors. This could have more discreetly placed.

Throughout the day there were a large numbers of visitors to the service. We saw they were made welcome by the staff. We saw that some people came to assist their relatives with their meals. This allowed them to continue taking an active part in caring for them.

There was appropriate information about the services and facilities available within the home. There were leaflets about other agencies that offered advice and support.

There were appropriate policies in place for issues such as dignity, equality and diversity and confidentiality. Staff we spoke with demonstrated a commitment to offering care in a way that respected people's diversity.

We spoke with a visiting healthcare professional who told us they felt things were better than they were six months ago. They felt the care their client received had improved.

Requires Improvement

Is the service responsive?

Our findings

We looked how people spent their day. We were told that the activity coordinator had left the home. We saw little activity or stimulation for people on either floor. We were made aware that some people who were cared for in bed had little access to any activities. We asked relatives if staff spent quality time with people in their rooms we were told this did not happen. People confined to their rooms often appreciate hand massages or ladies may like their hair brushed or just someone to chat with.

One person living in Pike View told us they had helped to plant bulbs in the garden. We saw that two people were knitting. In the main lounge there was a ceiling mounted laser light with display. This included images of butterflies, balls and bubbles that would burst open when the image on the table was touched. We also saw a member of staff engaged with a person playing Connect4. However, for the majority of people there was nothing provided to occupy them. We observed that two people were given dolls to hold. If doll therapy is being offered to comfort people who are living with dementia the dolls should be as life like as possible and suitably dressed. The dolls seen were not of this quality. Throughout the day we noted that the radio was on in the small lounge but the programme included a lot of advertising material. A more suitable range of music could have been offered.

The registered manager told us that the home had the use of the company's mini bus on Thursday and several people went out to local venues,

The standard of care records required improvement. We were advised there was a clear plan with a time scale in which to improve the standard of all care records across the home and it was acknowledged by management that there were differences in quality of the care plans between the nursing unit and the dementia nursing unit.

We found that there was some good evidence in the care plans we looked at to show people had been consulted on admission about their care about their ongoing medical support. However, we could not find supporting evidence that suggested that people had been consulted with changing aspects of their care planning. There were no statements that acknowledged whether people had understood or agree to the care plan.

We found that the use of bedrails was not included in the falls risk assessment. For example, what was the risk and was the use of bedrails an appropriate solution or could the risk of falling from the be reduced by other means other than bedrails. There was no specific risk assessment for the use of bedrails. However, we did see an up to date bedrail audit.

We asked the registered manager how they cared for people who were poorly and nearing the end of their life. We saw from the training records provided that staff had not completed training in end of life care. The registered manager told us that the home was supported by the local hospice to care for people nearing the end of their life. This meant that people could stay at the home to be cared for by people they knew and in familiar surroundings.

There was an up to date complaints procedure and this was displayed within the home and was detailed in the service user guide. We saw that complaints received had been responded to appropriately. However, the complaints analysis log had not been completed and no monitoring log was available. One person spoken with said they did not know how to make a complaint if they were unhappy about something. Another said, "I would tell the staff" and a third person said, "I would tell the truth if I wasn't happy. I have complained once or twice and they put it right there and then if they can". We saw a number of compliments cards had been sent to the service thanking the staff for the care and support provided.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place at the home. The family members we spoke to were comfortable about approaching the manager and staff when they had any queries or concerns. Family members knew who the unit managers were and some knew the home manager. One family member considered the home manager to be approachable and told us that, "The manager and staff were all "up front and didn't hide anything". Another family member commented that it had taken them several rnonths to realise who the home manager was as they didn't see her around the unit.

Family members told us that residents' and relatives' meetings were held periodically to discuss any issues or further developments within the home. At the meeting on 17 May 2018 issues around the food had been discussed about more choices at meal times and the variety of food offered. This had not been actioned.

The registered manager told us that staff meetings were held, however these were poorly attended. The registered manager needs to address ways in which all staff are able to attend meetings to keep up to date which what is going on within the home and other important issues. We saw evidence that staff supervisions and appraisals were ongoing.

Staff spoken with told us they were well supported by the registered manager and the management team. One member of staff said, "We get good support from the manager. We have good handovers at the start of every shift, written and verbal. We have staff meetings every three or four months".

Before our inspection we checked the records we held about the service. We found the registered manager had notified CQC of any accidents, incidents and safeguarding allegations as they were required to do. This meant we were able to see if appropriate action had been taken by the service to ensure people were safe.

We saw evidence of audit and monitoring checks in place. However, some of the checks had failed to identify hot water temperatures, gaps in recording in some of the care plans and monitoring charts. We saw the action plan from the fire risk assessment had not been completed as required. Following our inspection we received a completed action plan from the provider. These actions will be checked at the next inspection. The lack of evidence with regard to consultation with people/ relatives about care planning and changing needs addressing.

We found this was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a satisfaction survey carried out on a regular basis. We were provided with the feedback from the results of a recent residents/relative and staff survey. The results of the survey were positive. There was an IPad in the foyer for people to leave feedback about the home and the service provided.

The home worked in partnership with other agencies included the local authority, the Clinical Commissioning Group and the safeguarding team. The home was also part of the Care Home Excellence

programme.

This service cannot be judged as good in the well –led domain because we have identified breaches of the regulations of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure that people received a nutritional diet.