Lincolnshire Licences Limited

Holmleigh 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced inspection on 23 July 2018. Holmleigh 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.

Holmleigh care home offers accommodation for up to 44 older people with care needs. It is situated in the village of Navenby in Lincolnshire and offers accommodation on two floors. On the day of our inspection, there were 40 people living at the home.

At our last inspection in March 2016, we rated the service good. At this inspection, we rated the service as requires improvement overall and requires improvement in each domain.

There was 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.

Staffing levels were not always sufficient to meet the needs of people using the service due to vacancies and short term absence. People told us there were delays in staff responding to their needs and staff spoke about difficulties in providing the required levels of care, when planned staffing levels were not achieved. However, new staff were about to commence employment and the management team were taking steps to recruit additional staff. Safe recruitment processes were in place.

Systems were in place for the regular ordering and supply of medicines and people told us they received their medicines regularly. However, staff did not always stay with people to ensure they took their medicines. Processes to assess staff competency to administer medicines and to address gaps in the medicines administration record were not robust. We found some issues with the storage of medicines; however, following the inspection the management team took steps to address these issues. Systems were in place to maintain the premises and required maintenance and safety checks were completed. Staff had developed personal emergency evacuation plans for people to enable them to be evacuated from the building safely in an emergency. Most areas of the home were clean; however, we found some cleanliness issues in the kitchen and cleaning schedules were not being used to ensure a systematic approach was taken to cleaning the kitchen and catering trolleys.

People told us they felt safe. Processes were in place to keep people safe from abuse and avoidable harm. Staff reported incidents and accidents and a full investigation was completed following incidents and accidents to reduce the risk of reoccurrence.

Most of the people using the service were able to consent to the care and support provided and were able to

leave the home freely if they wished. However, we identified instances when the principles of the Mental Capacity Act and consent legislation were not fully adhered to. The registered manager told us they would review the decision making in relation to these immediately.

Staff received an initial induction and training was provided, to ensure they were competent for their roles. However, the management team did not have full oversight of training to enable them to assure themselves that staff training was up to date. This was an issue which they had identified during their quality audits and they were in the process of developing a training matrix, to record all training completed and the dates of training.

People had access to healthcare services as they required. Staff were alert to signs people were unwell and sought medical advice when necessary.

The majority of people told us staff were kind and caring towards them; however, we received some feedback about poor staff interactions and comments which were uncaring. We observed some positive communication from staff, but we also saw occasions when staff were task orientated and they did not always show empathy and understanding towards the people they cared for.

The care staff gave was responsive to people's individual needs and staff were knowledgeable about the people they care for. Care plans did not always provide sufficient information about the support people required and their preferences in relation to their care. A new electronic care planning system had recently been introduced and some of the issues we identified may have been due to the inexperience of staff in using the system. Activities were available for people in the form of entertainment, one to one and group activities. People told us they enjoyed the range of activities available.

People had confidence in the registered manager and the management team to address concerns. Quality audits were completed by the management team and the provider and some of the issues we identified during the inspection had been identified in the audits and actions put into place to address them. However, we found action plans and follow up of issues were not always robust and timely. Following the inspection, the management team acted immediately to address our concerns where possible, and develop further action plans to progress concerns that required a longer term approach. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as audits had not always identified the improvements required.

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 always safe.

Staffing levels did not always meet the needs of the people using the service.
Improvements were required in the management and administration of medicines.
Although the communal areas of the home were visibly clean, the kitchen and trolleys used to serve food, were not consistently clean.
Staff were aware of the actions needed to keep people safe; however, risk assessments were not always accurately completed.
Staff were aware of the actions needed to keep people safe from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Although most people had capacity to make most of their own decisions, staff did not always follow the principles of the Mental Capacity Act when this was in doubt.
Staff were provided with access to training, however, oversight of this by the management team was not fully established.
People were supported to eat a nutritious and balanced diet.
Staff ensured people had access to healthcare services and were alert to signs of ill health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed that care and support was task orientated at times and did not promote people's sense of well-being.
Most people told us staff were kind and respectful however, some people said there were occasions when staff were abrupt and lacked empathy.
People were involved in the planning and development of their care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always able to access care and support in a timely manner.
People were supported and cared for according to their personal preferences.
Care plans did not fully reflect people's needs and preferences in relation to their care and support.
People were supported to engage in a range of activities and the registered manager was exploring ways of tailoring activities to people's individual interests.
•There was a process in place for responding to and managing complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Effective and timely action was not always taken when quality audits identified issues. We identified issues during the inspection that had not been identified in the home's audit processes.
People had confidence in the registered manager who was approachable and responsive to the issues we raised.

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

This inspection took place on 23 July 2018 and was unannounced. The inspection team consisted of 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. An assistant inspector shadowed the inspection.

The provider had not sent us the Provider Information Return since 2016. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The most recent provide information return had not been submitted in February 2018 due to the unplanned absence of the registered manager immediately prior to submission and their continuing absence until two weeks before the inspection. We reviewed other information we held about the home including notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the local authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided. Healthwatch is the local consumer champion for people using adult social care services.

During the inspection we spoke with ten people using the service and two relatives. We spoke with the registered manager, the support manager, a deputy manager, three care staff, the chef, and a housekeeper.

We observed staff providing support to people in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not people were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included looking at all or part of four people's care records and associated documents. We reviewed records of meetings, recruitment checks carried out for four staff, staff rotas, staff training records and maintenance

and safety logs. We also reviewed the quality assurance audits the management team had completed.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely and in line national guidance. Medicines were stored in locked trolleys, cupboards and a refrigerator. The temperature of the refrigerator used to store medicines was monitored daily; however, the temperature of the areas where medicines were stored were not monitored. If the temperature is above the recommended limits, it can affect the shelf life of the medicine and advice from pharmacy should be sought. A member of staff said they were not aware of the requirement to monitor the room temperature and the registered manager told us they would immediately take steps to record the temperature. Following the inspection, it was confirmed that thermometers had been ordered.

Controlled drugs are medicines that are subject to additional controls to prevent them being misused or causing harm. We checked two of these and found the number corresponded with the number recorded in the controlled drugs register. The home had a process for staff to check controlled drugs at the staff handover between shifts, however, we found the checks were not completed between 6 July and 15 July 2018. A member of staff told us staff had been reminded to ensure the checks were completed consistently. Liquid medicines and topical creams were not always labelled with the date of opening. This is required to ensure they are used within the manufacturers recommendations. Systems were in place for the regular ordering and supply of medicines and people told us they received their medicines regularly.

Medicines administration records had a photograph of the person and a record of any allergies to reduce the risk of errors occurring. When we checked medicines administration records we found a gap in administration for four people over the previous three week period. When we checked further, we found that three of the four medicines were given and staff had not signed the record and in one case the medicine had not been administered. We observed the administration of medicines and observed staff did not always stay with people, to ensure they took their medicines. Some of the people we spoke with, told us staff sometimes left their medicines with them and did not observe them taking the medicines. This meant staff were signing to state they had administered people's medicines when they could not be sure they had been taken. The management team had completed a medicines audit and identified similar gaps in administration. They told us they had raised the issue with staff at staff handover. Staff administering medicines had received medicines administration training when a new medicines supplier was introduced. Staff were observed administering medicines when they received initial training and supervision of medicines administration when issues were identified; however, these were not documented. Immediately following the inspection, the support manager sent us a copy of a medicines competency assessment that would be used in the future.

We recommend the provider reviews the systems and processes for medicines administration to ensure their medicines policy is fully adhered to by all staff.

There was mixed feedback from people using the service about staffing levels at the home. Some people told us they felt there were normally enough staff on duty to meet their needs, while others told us there were not enough carers and this resulted in delays when they used their call bell or delays in staff assisting them to go to bed. For example, one person said, "It is difficult for the staff to get to us. They are usually

short staffed but have been very short for three weeks and mostly when we ask for something we are just told 'we are short today'." Another person said, "Last night it took an hour for someone to come to me."

Staff told us that when the planned number of staff were on duty, staffing levels were sufficient to meet people's needs. However, over the last three months they had experienced staff shortages, due to vacancies and sickness absence. The registered manager told us they used a staffing tool provided by their local commissioners to assess staffing requirements and they reviewed this every four months. A number of care staff had left the home in the three months prior to the inspection and they had not always achieved the planned staffing levels. Staffing rotas we reviewed indicated that planned staffing levels had not been achieved on nine out of the 21 days prior to the inspection and a similar number of night shifts in the same period. However, the registered manager told us they recruited three additional carers who were commencing employment within the next two weeks and recruitment was ongoing. They used agency staff when necessary; however, agency staff were not always available. The management team also provided support on these occasions.

Safe recruitment practices were followed to ensure staff were suitable to work with vulnerable people and those with complex needs. These practices included criminal record checks, obtaining a sufficient number of references from previous employers and proof of identity.

People felt safe at the home and relatives told us they felt their family member was safe. A person said, "They (staff) do safety checks during the night and they check the windows to make sure no one can come in." Another person said, I feel safe because the same staff are around all of the time and familiar faces are reassuring to me."

Staff were aware of the signs of abuse and the action they should take if they identified a concern. They told us they would report any concerns to the registered manager and if necessary would notify the provider's management team. They were not aware of the role of the local authority safeguarding team, however, staff said they could go to the care quality commission (CQC) or the police if necessary. Following the inspection, the support manager sent an action plan which indicated additional safeguarding training had been booked for staff for the following month. The registered manager was aware of their responsibility to make safeguarding referrals.

Staff were aware of how to keep people safe from avoidable harm and they gave us examples of ways they kept people safe whilst not unnecessarily restricting their freedom. Risks to people's health and safety were assessed, although these were not always accurately completed, and actions being taken to reduce risks were not always documented. For example, a person had fallen twice in the previous six months and their risk assessment stated they had not fallen. Reviews of risk assessments were not always completed regularly. However, staff were aware of the risks to people and told us of the actions being taken to keep people safe. We observed pressure relieving mattresses were being used to prevent people developing pressure ulcers when their condition put them at high risk of developing a pressure ulcer.

Staff told us that when incidents and accidents occurred they completed an incident form and they received feedback about changes required to reduce the risk of similar incidents occurring in the future. We reviewed the incident and accident forms for a period of three months prior to the inspection and saw staff had provided a good description of the incident, the immediate action taken to ensure the safety of the person affected, and a review had taken place of actions to prevent reoccurrence.

The premises and equipment were generally managed safely. The required safety checks including fire safety, water safety and other checks of the premises were completed. Equipment was serviced regularly

and the required safety checks of the premises were completed. However, new windows had been installed in part of the building and window restrictors were not in place, increasing the risks of people using the service. We informed the registered manager and following the inspection they notified us that restrictors were immediately installed on one window and additional restrictors were ordered for the remaining windows for delivery the following day. Staff had completed personal emergency evacuations plans that showed the support each person needed to evacuate during an emergency and staff were able to tell us how they should support people during a fire.

Care staff were aware of the need to prevent and control the spread of infection and we observed them complying with good hygiene practice, including using personal protective clothing such as aprons and gloves when required. The premises were mostly visibly clean; however, we observed some items such as moving and handling equipment, where cleanliness could be improved. We saw a bath chair hoist was not clean on the underside and brought this to the attention of the registered manager and a cleaner who agreed it would be added to the schedule. Other moving aids were in need of more regular cleaning. Staff said other hoists were cleaned by night staff but records were not maintained to confirm this.

The kitchen had been inspected by environmental health officers in January 2018 and received a 5 star rating. On the day of the inspection, we found stainless steel surfaces were clean and clutter free, fridges and freezers had been defrosted and were clean. Plastic files containing menus and diet information were visibly dirty. We found the hand wash basin and parts of the floor under work surfaces were not clean. We also noted that the heated trolley used to distribute meals and two other trolleys used for serving meals were soiled with dried food. Catering staff said they cleaned the trolleys monthly. The catering staff said they did not complete a cleaning schedule to record when cleaning had been completed. In addition, the chef had not completed food hygiene training since 2009. The registered manager, told us they would address the issues immediately with catering staff and ensure a cleaning schedule was re-introduced. Following the inspection, an action plan provided by the support manager indicated that a cleaning schedule had been introduced and a meeting was booked with catering staff to address our concerns.

We recommend the provider increases the reviews of cleanliness to ensure standards of hygiene and cleanliness are maintained.

Requires Improvement

Is the service effective?

Our findings

People's needs were assessed and care was generally provided in line with current guidance. We observed best practice guidance for staff on aspects of care, such as safe moving and handling, grading and management of pressure ulcers and safe use of bed rails, were displayed within the home. We observed staff assisting people to move safely. Staff had access to policies developed by the registered provider that were based on legislation and standards in health and social care to ensure that best practice was communicated to staff.

People's diverse needs and characteristics were recognised and accommodated to ensure people were not subject to discrimination. Staff we spoke with and the care plans we reviewed, showed these characteristics had been considered when providing care for people. The registered manager told us of support given to staff with additional needs to enable them to work effectively at the home. For example, a member of staff had severe dyslexia and had completed key skills training and was undertaking a nationally recognised qualification for their role with additional support.

People were supported with their day to day healthcare. We saw people were supported to access their GP when they were unwell and there was evidence of the involvement of other professionals such as chiropodists and opticians. People we spoke with and their relatives confirmed this. A relative said, "Staff are on the ball and if there are signs that (family member) has an infection, they will always check and they will let us know." The registered manager told us a dentist visited the home routinely twice a year, to enable people to access dental care. A GP visited the home weekly and staff were able to schedule reviews of people who did not require emergency care. They reviewed all the people using the service annually. An optician was visiting the service during the inspection and they confirmed that they provided a regular comprehensive service for people and staff followed through on their recommendations.

People and their relatives felt that staff were trained and competent for their roles. Staff completed an induction when they commenced employment and received mandatory training in topics such as person centred care, moving and handling, fire safety, infection prevention and control and safeguarding vulnerable adults. However, records of training were not always completed and it was difficult to determine whether individual staff had completed all the required training. The registered provider was in the process of introducing a training matrix to enable managers to see at a glance the dates when training had been completed, and when refresher training was due. At the time of the inspection, the matrix was being populated and it was not possible to gain assurance that all staff had completed essential training. Staff were offered the opportunity to undertake nationally recognised qualifications in care and additional training topics were identified and training provided. We saw staff had received supervision and a supervision matrix had been developed to ensure that supervision was planned and completed in a timely manner.

People were supported to eat a balanced diet. We received mixed feedback on the quality of the meals. A person said, "Some days the food is very nice, but not always. I think that when there is a lot of us it is hard to get it right." We received other similar comments about the variability in the quality of the meals provided.

A varied menu was provided and when people were admitted to the home, their preferences were recorded and provided for the chef. We didn't see evidence of consultation with people using the service about the menus on an ongoing basis; however, people were able to ask for an alternative if they did not want to eat the options from the menu. Fresh fruit and snacks were available, although some people we spoke with, did not know they could ask for them. We did not see fresh fruit and snacks in the communal areas to enable people to help themselves and some people may have been reluctant to ask.

The registered manager told us there were plans to introduce a family meal on alternate months, to enable people and their relatives to come together and create a social occasion for all to enjoy.

Care records we reviewed showed that people's nutritional needs were assessed and nutritional care plans identified their support needs. The registered manager told us that people were weighed monthly or more frequently if they were losing weight. However, their care records did not always confirm this. We reviewed the care records of three people who were classified as being underweight using the national body mass index indicator. We saw they had been losing weight and their care plans did not refer to this. In two of the three cases, their care plans did not indicate that nutritional supplements were being provided, although when we checked with the staff and the medicines administration records, we identified that supplements were being provided. Following the inspection, we were provided with evidence that people were weighed monthly, although their weight had not been transferred to their care records. This provided us with some assurance that weights were being monitored, although did not provide assurance that the results were being used to influence the care provided.

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 so that they 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 the Deprivation of Liberty Safeguards (DoLS). 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.

We found staff knowledge of the MCA and the implications for their practice to be variable. Records indicated that most staff had not completed training in the MCA and DoLS. Care records indicated that people had consented to their care and support, and people told us, staff asked their permission before providing care. A person said, "I can do what I like, when I like." The registered manager told us all the people using the service were able to give informed consent and had the capacity to make their own decisions, therefore mental capacity assessments were not required. However, we discussed two people with the registered manager or staff, that were living with dementia and the information in their care records suggested they may not have had the capacity to make their own decisions about specific aspects of their care. For example, a person had requested a key to their room and it was not provided for safety reasons. The registered manager agreed that in these cases a mental capacity assessment should be completed. Following this, either a best interest decision should be made, or if the person had the capacity to make the decision, consent should for the specific aspects of their care be obtained. They also said they would ensure all staff received training in the MCA and DoLS.

We recommend the provider reviews the requirements for mental capacity assessments when people have

cognitive impairment and may not be able to make all decisions in relation to their care and support themselves.

The home did not have restrictions on people leaving the building. The ground floor bedrooms had patio doors which were only locked at the person's request and at night. The front door to the home was locked in the evening. At other times, staff were able to monitor people entering and leaving the building to maintain security.

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind and caring. One person said, "Everyone is kind." Another person said, "The staff are very kind, but they do get tired." A third person said, "The staff are fine. I have no quarrel with any of the staff." Relatives felt staff were caring and one relative said, "Nothing is too much trouble for staff."

However, two people we spoke with gave us examples of instances when they felt staff had been inpatient or short with them when they needed assistance. For example, a person said when they had rung their call bell, the way in which the member of staff asked them what they wanted was sharp. A person told us they had observed a situation where they felt a member of staff had been abrupt and rough when they were assisting another person with their shoes. Another person told us that when they asked for their jug of fruit squash to be topped up, staff would tell them they hadn't got time. When speaking about this, people tended to refer to it, in the context of pressure staff were under due to shortages of staff. For example, one person said, "I think it is sometimes hard for the staff as they are under a lot of pressure."

We observed the mealtime experience in the two dining rooms. In both rooms, we found there was very little communication by staff with people using the service when staff served people with their meals. Staff placed a plate in front of each person with no explanation and without checking with them that the meal was what they had ordered, or that they had everything they required. This did not create a social experience for people and the room was almost silent. On the day of the inspection the chef had substituted plaice with fishcakes as one of the choices, due to a missed delivery. However, no adequate explanation was given to people and they were not given the option of changing their mind. When one person was given their meal, they said they didn't want it, but they were not offered an alternative. Although staff went back to check on the person during the meal they still did not offer an alternative or spend time with them encouraging them to eat. This demonstrated a lack of interest in the welfare of the people they were caring for.

At times, staff appeared very task orientated and did not interact socially with people. There was no exchange of news or pleasantries and no communication by staff to increase people's sense of well-being. However, we did hear a carer respond to a call bell in a person's bedroom and they were bright, pleasant and cheerful.

Following the inspection, the support manager informed us that additional staff training was being provided and the issue addressed within supervisions with staff. We recommend that the provider reviews the way in which staff communicate with people, to enable issues to be more specifically identified and addressed.

People were able to see their relatives and friends at any time and the people we spoke with said staff welcomed them to the home.

People's cultural and religious needs were met. The registered manager told us they had arranged for people to be supported with regular visits from leaders of their chosen faith. There was no one requiring an independent advocate at the time of the inspection.

People's privacy was maintained by staff. We observed staff knocking on people's bedroom doors before entering and people had the choice of whether they wanted to stay in their rooms or spend time in the communal areas. People we spoke with told us staff closed the doors and curtains when providing personal care and knocked on bedroom doors prior to entering. One person said, "They are very conscious of my privacy, they close the curtains and knock on the door. The other day a young carer helped me to have a wash and was very careful about covering me so that I wasn't embarrassed."

People and their relatives told us they were involved in the development and review of their care plans. They said staff spoke with them about their care needs and how the support should be provided. Relatives told us that staff contacted them about any changes to the person's condition, for example if they had an accident or if they became unwell. A relative said, "Staff always ring if there is an issue and keep us in the loop."

Requires Improvement

Is the service responsive?

Our findings

Care plans were in place to identify the care and support people required; however, the amount of detail provided was variable and they did not always contain key information about the person's needs. The home had implemented an electronic care planning system approximately 10 weeks prior to the inspection and although staff had been provided with training in the system, this may have had an impact on the quality of the information in the care plans. Care plans for people's personal care frequently contained a good level of detail about the person's support needs and their preferences in relation to their personal care.

Pressure ulcer prevention care plans were generic and contained statements such as, "Introduce a re-positioning schedule," or, "Review mattress and seating." These statements did not provide clear instructions for staff on the assistance the person required to move their position, the frequency of re-positioning required, or the type of mattress and seating required for the person. In addition, we found staff did not record regularly that they had re-positioned the person. A person's care record stated they should be checked two hourly at night but records of night checks were not consistently completed and records indicated they were not checked after 4.30am. Another person had a pressure ulcer and although we were told it was healing well, there was no information about it in their care plan. A community nurse visited to dress the wound two or three times a week, however the person's care plan did not identify the action staff should take to encourage wound healing, prevent deterioration of the ulcer or prevent a further pressure ulcer developing.

Assessments of a person's communication needs were not fully completed and did not correspond with the information a member of staff gave us about the person's ability to communicate. The assessment stated the person communicated minimally or irregularly and did not state whether they used a hearing aid or their level of understanding of verbal communication. However, their dementia care plan stated they had short term memory problems and that communication should be kept simple and limited choices given. In contrast the communication care plan for a person who had had a stroke was detailed and informative. We discussed the issues we identified with the care plans with the registered manager and they told us they would ensure the documents were reviewed and updated to ensure they were reflective of people's current needs. They felt the issues were in part due to staff familiarity with the electronic system and when it was fully embedded the system would improve record keeping generally.

Feedback from the majority of people using the service was that staff were responsive to their individual needs and they could choose how and when they received support; However, sometimes they felt the individual staff on duty or the number of staff available, impacted on the responsiveness of care. A person said they liked to have a bath three times a week and that this was recorded and they were offered a bath on those days. They said this was the way they preferred it, and they could ask if they wanted an additional bath or shower. However, another person said they would like to have a daily shower, but they were not able to have a shower every day. A third person told us they liked to go to bed by 10pm, but sometimes it was after midnight before staff were able to assist them. Other people, said they were left for extended periods when they needed assistance in getting back to bed after using the toilet. This showed not all staff were responsive to people's needs and preferences.

The registered manager was aware of the Accessible Information Standard which applies to people who have information or communication needs relating to a disability, impairment or sensory loss. Some information was available for people in accessible formats and staff provided assistance to enable people to remain as independent as possible when they might have difficulty in accessing information or services. We observed some people had been provided with telephones with large buttons to enable them to use the telephone independently; large print books and talking books were also provided. The registered manager told us that the home had access to laptop computers and people were assisted to use tools such as video calls to contact their relatives.

Care records contained information about the person's previous life history and their interests and we found staff were generally knowledgeable about this.

People told us there were a range of activities taking place in the home on a daily basis and they could choose whether or not they participated. One person said, "There is always something going on; we get sent a booklet with the activities." They spoke about visiting entertainers, school children visiting to entertain them and a person who played the piano. A person said, "We have exercise sessions, word games, bingo." Another person said, "On Saturday we played skittles and I noticed that lots of ladies who usually sit asleep joined in and became quite competitive. When singers come into the home they are usually very popular and lots of people join in." Staff mentioned quizzes and sports activities which the activities coordinators initiated. Raised flower beds had been created in the garden to enable people to participate in gardening activities and we were told of people who enjoyed doing this.

One person said they would have liked to have had the opportunity to go on external trips and visits, but this was not possible. The registered manager told us they had previously had frequent external trips; however, when they had suggested or arranged them, people had not wanted to go. For example, it had been agreed people would visit the local war memorial, but on the day, when additional staff had come in to support them to do this, they had not wanted to go. The registered manager said they had also suggested a trip to the coast, and people had said it was too long to sit on a bus. The registered manager said they were looking at the preferences of people currently using the service, to enable them to tailor activities around what people wanted to do and their individual interests.

The home had not received any formal complaints in the last year. The registered provider had a complaints policy that outlined the process for investigating and responding to complaints and the response times. It provided information about signposting the person to the Local Government Ombudsman if the complainant was not satisfied with the response. People we spoke with and their relatives said they had not had any cause to make a formal complaint. Three of the people we spoke with said they would not want to raise a concern as they, "Wouldn't want ramifications" or "It might come back on me." None of them, identified a time when they had raised a concern and it had not been dealt with appropriately and therefore this may not have been a result of a negative experience, and may have reflected a more general reluctance to complain. When made the registered manager aware of this feedback they were disturbed that this was the case and said they would look at action they could take to provide reassurance to people and encourage them to speak up if they had a concern. Relatives told us that when they had raised small issues they were always dealt with immediately and were resolved. They all felt able to speak with the registered manager and had confidence in her to deal with the issues.

There was no one receiving end of life care at the home at the time of the inspection. However, we observed that advanced care plans had been developed and provided basic information about people's wishes for the end of their life. The staff training matrix indicated that a small proportion of staff had received training in end of life care.

Requires Improvement

Is the service well-led?

Our findings

Audits were completed by the senior management team that identified where improvements were required. The management team told us they were committed to improving the service. They immediately provided an action plan to address the concerns we raised. However, the audits we saw, had not identified all the areas of concern we identified on inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as audits had not always identified the improvements required.

The registered manager had recently returned to the service after an absence of five months. During their absence, the deputy manager had also left the service. The registered provider had provided additional support during the registered manager's absence and two new deputy managers had been appointed. However, these issues had impacted negatively on the leadership of the service in the short term. Several of the people we spoke with told us they had confidence in the registered manager but their absence had been felt.

The registered manager was clear about their responsibilities and their obligation to notify us of significant events in the service. It is a legal requirement to display the last CQC rating in the service and on provider's website and this requirement was met. This is so that people,
visitors and those seeking information about the service can be informed of our judgments.

Staff we spoke with said they would be comfortable to raise concerns with the registered manager or their deputies and that they were all approachable. They were aware of the whistleblowing policy and said they would use this if necessary. The decision had been taken to appoint two deputy managers to provide additional support which extended to weekends. The registered manager told us they had received feedback from people using the service and their relatives, during residents and relative's meetings, that a management presence at weekends would be beneficial.

A staff meeting was held in March 2018 and minutes from the meeting indicated that attendance was good and staff were able to contribute their views. It was acknowledged at the meeting that it was some considerable time since the last meeting, and that meetings would be held on a monthly basis subsequently.

People we spoke with did not recall being invited to discuss ongoing issues and developments in the home and did not recall being asked for feedback on the quality of care provided. For example, one person said, "I have never been asked my opinion; they don't seem to do surveys." Another person said, "I can't remember ever being invited to a meeting." However, the registered manager showed us minutes of a meeting that was held for people using the service and their relatives in May 2018, although there was no record of the number of people and relatives that attended. A range of issues were discussed including staffing levels. There was also a record of a brief feedback questionnaire being completed by 10 people, although there was no record of any comments made by people and no actions from this.

During the registered manager's absence representatives of the provider had completed quality audits and following the appointment of the two new deputy managers they had also completed quality audits. We reviewed the results of the audits and found some, but not all, of the issues we identified, were also identified in the provider audits. Actions required as a result of the audits were identified and we found a number of changes had been put into place as a result. For example, the service had introduced a new system for the management of medicines and a new pharmacy supplier. However, this had not proved to be fully effective in addressing all of the issues. We asked the deputy manager about actions taken to address the gaps in the medicines administration records which were identified in the audits completed in March 2018 and April 2018, and which we found to be still an issue at the inspection. We were told staff had been reminded of the importance of signing the administration records and of undertaking controlled drug stock checks. However, no more regular checks of the MARs were completed to enable managers to speak with staff individually when they failed to sign the charts.

The development of a training matrix and supervision matrix to address the poor quality of the training and supervision records had been initiated, although the training matrix was not completely populated. The cleanliness of the kitchen was raised as an issue in the provider audit in March 2018, although an audit in June 2018 found the kitchen to be clean. We identified issues with cleanliness of the kitchen at our visit.

We identified a number of issues with the accuracy and content of care records. This may have been due in part to the recent introduction of an electronic record system and staff familiarity with the system. We recommend the provider reviews the support required for staff to ensure care records accurately reflect people's care and support requirements and their personal preferences.

We recommend that the audit programme is reviewed to enable more frequent targeted audits of specific parts of the service to be conducted when issues are identified and clear action plans with timescales and responsibilities provided for staff, so that expectations are clear. This will ensure that improvements to practice are implemented and sustained.

Following the inspection, the registered manager and support manager took immediate steps to address the issues raised in our feedback and they sent us an action plan to identify the action being taken and future planned action.

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 17 HSCA RA Regulations 2014 Good governance Audits had not always identified the improvements required.