Alliance Care (Dales Homes) Limited

Meyrick Rise

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Meyrick Rise 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.

Meyrick Rise was registered for 73 people. There were 31 older people living in the home at the start of our inspection. People had a variety of care and support needs related to their physical and mental health.

This unannounced inspection took place on 5 and 7 June 2018. This was our first inspection of the service since the provider had changed.

There was not a registered manager for the service. 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 had been an unsettled period of management at the home. A new manager had been appointed and they were starting the process to register with the CQC.

Staff understood most of risks people faced. However, the risks people faced were not always recorded and shared consistently and care delivery did not always act to reduce these risks. People did not always receive their medicines as they were prescribed. The provider put plans into action to respond to these concerns.

Staff encouraged people to make decisions about their lives. However, care plans did not always reflect that care was being delivered within the framework of the Mental Capacity Act 2005. This meant people were at risk of receiving care that was not in their best interests or was overly restrictive. The failure to apply the MCA appropriately had led to Deprivation of Liberty Safeguards not being applied for when necessary for a person. The provider started to address this immediately.

Quality assurance systems had not been effective in identifying the issues identified during our inspection. Auditing processes were updated to improve their efficacy.

Everyone described the food as good. The systems in place to ensure people had enough to eat and drink were not effective and people's meal time experience was varied. The provider put plans in place to address this immediately.

Care staff were consistent in their knowledge of people's on-going care needs and spoke confidently about the support people needed to meet most of these needs. Some people were not, however, receiving care as outlined in their care plans and this put them at risk. We highlighted these concerns and were told this would be addressed immediately.

Staff told us they felt supported in their roles and had undertaken training that provided them with the necessary knowledge and skills. There was a plan in place to ensure staff received refresher training as deemed necessary by the provider.

People had support and care from staff who had been safely recruited.

People were engaged with activities that reflected their preferences, including individual and group activities. People and relatives felt that they were listened to and their views were considered and acted upon.

The environment was clean and maintained.

People told us they felt safe. Staff knew how to identify and respond to abuse and told us they would whistle blow if it was necessary

People were largely positive about the care they received from the home and told us the staff were kind. Staff were cheerful and treated people and visitors with respect and kindness throughout our inspection.

There were breaches of regulation with respect of safe care and treatment, the application of the Mental Capacity Act 2005, person centred care and the governance of the service. You can see what action we told the provider to take at the back of the full version 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?

Requires Improvement

The service was not always safe. People did not always receive their medicines as prescribed and risks were not managed, monitored and communicated effectively.

People felt safe and there were enough staff to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not always provide care within the framework of the Mental Capacity Act 2005. This lack of understanding regarding the MCA had also meant that a DoLS had not been applied for.

People told us they had access to healthcare when they needed it.

People's needs had been assessed and they were cared for by staff who understood these needs.

People did not always have food and drink in a way that met their needs.

Is the service caring?

Good

The service was caring. People received compassionate and kind care from staff.

Staff developed relationships with people and took the time to get to know them individually.

They treated all people, visitors and colleagues with dignity and respect.

People and their relatives were listened to and felt involved in making decisions about their day to day care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care delivery did not always reflect the needs that had been identified at assessment and people did not always receive the support they needed. The

provider addressed this when identified.

People, and relatives, were confident they were listened to and knew how to complain if they felt it necessary. People enjoyed a range of activities.

Is the service well-led?

Requires Improvement

The service had been through a period of unsettled leadership. A new manager had been appointed. People, relatives and staff had confidence in the management and spoke highly of the support they received. There were systems in place to monitor and improve quality including seeking the views of people and relatives. These had not been effective in highlighting the concerns identified during our inspection.

The findings and advice of other professionals had not been used to improve the quality of the service. □

Meyrick Rise

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 the 5 and 7 June 2018 and was unannounced. The inspection team was made up of two inspectors, and a specialist advisor with current clinical experience with older people.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information received from other parties. The provider had not submitted a Provider Information Return (PIR) because we had not requested that they do so. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather this information during our inspection.

During our inspection we observed care practices, spoke with 11 people living in the home, three relatives, nine members of staff, the manager and two representatives of the provider. We also looked at records, including medicines administration records, related to 17 people's care, and reviewed records relating to the running of the service. This included seven staff records, quality monitoring audits and accident and incident records. Following the inspection, we asked the manager to send us further information including: the safe administration of medicines, end of life care, training dates, information relating to a person's DoLS conditions, Power of Attorneys and some management information. We received this information as agreed on 12 June 2018.

We also spoke with social care professionals who had worked with the service.

Requires Improvement

Is the service safe?

Our findings

Staff were able to describe the majority of risks people faced with confidence, however we found that some risks people faced were not managed effectively and this put people at risk of harm. One person was assessed by a speech and language therapist as needing to have a fork mash able diet to reduce their risk of choking. Their safe swallow plan also highlighted that they needed to be supervised when eating because of this choking risk. On the first day of our inspection we observed them start to choke in the dining room with no staff around. We made a member of staff aware and they sat with the person whilst they recovered their composure. The member of staff available in the dining room did not have training in how to respond to a choking incident. We noted that the person was eating their breakfast in their bedroom without supervision. We spoke with the manager and provider about this and they told us that this person was being encouraged to have their breakfast in the dining room and that there would always be a nurse in the dining room. On the second day of our inspection we observed this person was given their vegetables cut but not fork mashed. We spoke with the manager and they addressed this. They told us that the person had requested this. Following our inspection, the provider shared that they had updated the person's care plan to reflect their wishes and understanding of the risks.

Another person needed their drink to be thickened for them to drink it safely. This had been left in their room with them and had solidified which put them at risk if they had drunk it. We raised this with a member of staff who addressed this immediately.

Records related to the monitoring of people's experience were not complete or used to reduce the risks they face. For example, one person who was being tested for a urine infection when we visited had their fluid intake recorded. This had not been tallied to inform how much they should be encouraged to drink. This meant that there was a risk that the person was not drinking enough to protect them from developing infections.

Another two people were identified as being at high risk of developing pressure wounds. Records did not reflect that the amount of fluid they were drinking or the regularity of support they received to move were being monitored. This meant they were at risk of developing pressure sores and one of them had a red area of skin. The care plans of these two people did not reflect the care being delivered. One of the people's care plan stated they used an air mattress to protect their skin. This was not the case. The other person's care plan stated that they should be helped to move every two hours during the day time. The monitoring form in their room stated every four hours.

Two people were described in their care plan as requiring hourly checks for their safety as they would not always be able to seek staff support themselves. We saw that there were large gaps in the recording of these checks meaning it was not possible to tell if they had been visited. We visited one of these people during our inspection and saw that staff had not been to check on them for 90 minutes. This failure to monitor the risks people faced people put them at unnecessary risk.

Some people had charts in place to monitor their bowel function. This was important to ensure their health

and wellbeing. We saw that two people were recorded as having gaps of more than seven days and more than 10 days between opening their bowels. This had not been highlighted or led to any intervention to support bowel function. People were put at risk because monitoring systems were not used to reduce the risks they faced.

We spoke with the provider and manager about this and they sent us detail of increased oversight of the monitoring associated with risk management. They had a meeting with staff to explain the importance of recording to ensure people could receive the care and support they needed to remain safe.

Staff responsible for the administration of medicines had undertaken training and had their competency assessed. This had not, however, always resulted in appropriate medicines administration for people.

Medicines administration was not robust. Whilst people told us they received their medicines correctly we found a number of errors associated with ineffective systems. This increased the risk to people that they would not receive their medicines as prescribed. We found a cream that was no longer prescribed had been given to a person on three occasions and this had not been identified. The cream was in the medicines trolley open but without a date to show when it had been opened. We saw two further people's creams with no opening date. Guidance had not been sort from a pharmacist to ensure that medicines hidden in a person's food and drink would still be effective given in this way. This was not in adherence with safe administration or the provider's policy. We found thickener in one person's bedroom. It was not labelled as being theirs. Thickener should be kept securely as if ingested it can be dangerous. We told a member of staff about this and they removed it from the person's bedroom.

Information was not available to help staff make decisions with people about when to take medicines that are only taken when required (PRN). We reviewed the records of three people who had medicines prescribed in this way and found none of the information was available. The reason for giving this medicine was not recorded. Another person had not taken a medicine prescribed to control stomach acid on one day. It had been signed for as given as prescribed but remained in the blister pack.

We spoke with the manager and provider about these errors. They responded by doing a review of medicines on both floors of the home. They explained that some of the PRN protocols had been removed in error. They ensured that these were updated and added protocols where they had not been done. They also sought guidance from a pharmacist and gathered detailed information about how best to give the specific medicines involved covertly. During their review they found that pain scales were available but not used. They ensure this process was shared with the nurses.
Another person had been given medicine unsafely. We spoke with the manager and provider about this. They put a process in place to ensure that this would not happen again.

People did not always receive their medicines as prescribed and people were at risk of not receiving safe care and treatment because staff did not record and communicate their needs.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people took medicines that required stricter controls by law. These medicines were being administered and stored safely. Some medicines were being used that required cold storage, there was a medicine refrigerator at the service and the temperature was monitored and within the acceptable range. The temperature of the room where medicines were stored was also monitored and was within the acceptable range.

People told us they felt safe and relatives also shared this view. One person told us: "I have never felt unsafe. I feel in good hands." A relative told us: "I feel able to relinquish responsibility. The nurses are on it." People that the staff made them feel safe because they were lovely. Some people could not communicate with words about their experience of care. They appeared relaxed around staff indicating their comfort and ease.

There were policies in place to support good safeguarding practice. Staff had all received training in how to follow the safeguarding process and could describe how they would report suspected abuse.

Equipment owned or used by the registered provider, such as specialist beds and hoists, were suitably maintained. However, we noted that several bed rail covers needed replacement as the easy clean cover had cracked. After the inspection we asked the manager about this and they told us that these cracked covers had been picked up in their deep clean system and replaced. Effective systems were in place to ensure equipment was regularly serviced and repaired as necessary.

There were enough staff on duty to meet people's needs. Although people told us that staff were sometimes busy, and we saw this was the case, staff also had time to sit and chat with people and did so throughout our visits. Staffing levels were determined with a dependency tool that reflected the support people needed. The service also employed cleaning, kitchen, and maintenance staff to help ensure the service ran effectively. These staff were actively involved with people living in the home and communicated with the care team.

The service had an appropriate recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. Staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check.

Staff received training in safety processes and practices such as moving and handling, fire safety and infection control. Staff understood their responsibilities to ensure infection control was managed effectively and we saw they used appropriate protective clothing when supporting people with personal care or cleaning. People's rooms and communal areas were cleaned throughout our inspection.

Accident and incident reports were all reviewed and actions taken as necessary. These had included records of medical assistance being sought for people. Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary.

Requires Improvement

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

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

Staff had received training in MCA and demonstrated an understanding to the principle of gaining consent before they carried out personal care. They told us they checked with people before providing any care and explained what they were doing. We saw that people were offered choices such as where they wanted to sit and whether to get involved with activities. However, staff who updated care plans had not understood how to act within the law when a person did not have capacity to consent to their care. This meant that care was being provided without the framework of a best interests decision or the consent of a person who had the legal right to make decisions about a person's care.

There was further mixed evidence related to the application of the MCA. We saw one person's MCA records supported staff to understand how best to support the person to maintain their capacity to make decisions. However, restrictive care practices had not always been considered by following this process. For example, one person who was not able to make some decisions was described as having 'full capacity'. This person's care was not being provided within the framework of the MCA. Another person was described as being unable to make decisions about their care and their care plan indicated that they relied on a relative to do this. The relative did not have legal status to make decisions on their behalf. Care records indicated that this person did not need any MCA assessments.

Where people had made provision for others to legally make decisions for them regarding their health and welfare this had not been considered by the provider in respect of consent to care. This meant that care was not being provided legally. We spoke with the provider and manager about this and they undertook to gather the information they needed and then told us they would review people's care plans with the people who had the legal status to consent to their care. We were not able to review if this had happened.

There was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This failure to follow the MCA meant that a DoLS had not been applied for appropriately. We spoke with the provider about this and they ensured that this application had been made by the second day of our inspection.

Another person had a DoLS authorised with conditions about the person being offered opportunities to go out and that records must kept of this. This condition had not been met and staff were not aware of conditions in place.

We recommend that you seek appropriate guidance to ensure that systems to meet the conditions of people's DoLS are met.

People told us that staff had the skills they needed to support them. One person told us: "The staff are well trained." Staff told us they felt supported by their colleagues, the manager and the operations manager. They commented that they had access to training to support them in their roles. At the time of our inspection we noted that some staff were overdue refresher training and we discussed this with the training lead. They showed us that a group of staff would be attending this training soon after our visits. Nursing staff were being supported through the revalidation process and told us that when training needs were identified due to new treatments or medical conditions they could access training quickly. An example of this had been recent syringe driver training undertaken by nurses in the home.

Newer staff had also had the opportunity to undertake induction training and shadow more experienced staff. If staff needed to undertake the Care Certificate this was available. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. The induction process supported staff to familiarise themselves with the organisation's' approach to human rights, equality and diversity. This was reflected in staff understanding and they spoke about the importance of learning about people and what mattered to them.

People were supported with their day to day health needs in conjunction with health care professionals. One person described the nursing care they had received in glowing terms and this person's relative commented on how impressed they were with the attention to health needs. We saw liaison took place with people's GP's to ensure the most appropriate treatment. For example, discussions and agreements were being made about ensuring the most appropriate tests took place for a person with physical and mental health needs.

Records showed that people had regular contact from a range of health professionals such as: nurses, GP's, physiotherapists and consultants. We also saw that a person had been referred to the dentist after a request for assistance with this was made by a relative.

The physical environment was being used in a way that supported people to maintain relationships and spend their time meaningfully. People used communal areas and their bedrooms and there were quiet places throughout the home for people to meet with friends and family. There was access to secure outdoor spaces where seating and planting provided a pleasant environment. Further work was planned for the garden area to make it more accessible to all the people living in the home. People told us they enjoyed the environment but also commented that maintenance tasks could take a while to address. This included changing light bulbs and plumbing issues.

Meyrick Rise was not a specialist dementia service. The environment was, therefore, not designed to reflect the specific needs of people with dementia and was designed to create a homely environment. We saw that some people who were living with cognitive difficulties moved independently and found their way around the building. We spoke with the manager about the use of research around assistive equipment. They explained that the home was continually developing to reflect the needs of people living there. This approach incorporated individual preferences and research. For example, they described how they had

introduced brightly coloured crockery but the person had not wanted to eat from this.

Before moving into the service people had their needs assessed across a wide range of areas. This assessment process identified initial support needs. We asked about how people were protected from discrimination and were told that people were treated with respect and dignity from initial contact onwards. Staff described how each person was treated with respect. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. Admission assessments on people's files identified basic needs. These assessments were used to develop a care plan for the person and guidance from professionals was incorporated.

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence was being explored. There was a call bell system which people could use to alert staff if they needed them. The provider told us they were investigating an electronic care planning system and that this would be implemented at an appropriate time for the team at Meyrick Rise.

People were asked about what they liked to eat as part of their assessment process and this included any dietary, cultural or religious needs. We saw that pictorial menus helped people to choose their meals and that the choice of main meal was made at point of service. People commented positively on the food making comments such as: "delicious food" and "I love the food." The provider organisation was introducing fine dining standards across their services and staff were undergoing training in this when we visited.

People had varied experiences of mealtimes. People enjoyed a social experience however this was affected for some by meals not being brought to people sitting together. This meant that in a small social group some people had finished eating before others were served. People had also been provided with a menu that did not reflect one of the meal options available. Another person's meal time experience was impacted because their vegetables were brought to them in a form they could not eat. This was identified by the member of staff supporting the person and had not been avoided by the clear guidance available in the kitchen. They had to be returned to the kitchen and arrived after they had finished eating their main course. People who had pureed diets did not always have access to varied alternatives when other people had a snack. We were told that yoghurts and mousses were available but we checked with staff and this was not the case during one of the snack times we observed. They were receiving milkshakes to ensure appropriate nutrition and hydration but their choices were restricted. Other people benefitted from individualised service and support. One person ate early to fit with their choice of daily activity and another person retained independence by using adaptive equipment.

Some people had been identified as being at risk because they did not want to eat or drink enough to maintain their health. Food and fluid charts were kept and people's intakes were monitored and their weight was regularly checked. We observed these records were not an accurate reflection of people's dietary intake. This put people at risk because staff could not monitor whether they had eaten and drunk enough to stay well. We spoke with the provider about this and they addressed it with the staff team during our inspection. We were told that this had started to improve but we were not able to check the sustainability of this.

The Food Standard Agency inspect standards of hygiene and safety to award a rating. They had visited Meyrick Rise in July 2017 and awarded the home the highest five star rating.

Good

Is the service caring?

Our findings

The service was caring. We heard comments such as: "The staff are fantastic; always happy and cheerful. It is nice to speak to happy people.", "The staff are absolutely lovely people. They listen. They are courteous and kind.", "They are kind – they ask- they come in and sit and talk to me.", "Everyone has time to talk even the cleaners." and "Nothing is too much trouble." The relatives we spoke with said they could visit the service at any time and always felt welcome. One relative spoke about how caring they believed the staff to be and how important this was to them. They told us about a time they had arrived unannounced to visit and: "Heard them (staff) singing and laughing and giving (relative) a kiss on the cheek – it is genuine care"

Staff all told us they enjoyed their work and enjoyed spending time with the people they supported. They were compassionate and caring and spoke with enthusiasm for their work. They all expressed their motivation for their work being the people living in the home making comments such as: "The residents here are all lovely." They also spoke with respect for their colleagues, making comments such as: "Everyone here cares."

Throughout our inspection there was a calm and welcoming atmosphere in the home. We observed care staff, housekeeping staff and managers interacting with people in a caring, respectful and compassionate manner. For example, when cleaners knocked on people's doors they spent time interacting with the person. Whilst attentive to people's care and social needs the staff also respected the person's space and how they liked to be supported.

People were encouraged to use all the communal areas in the house. People using the communal lounge were relaxed in each other's company. We saw that staff took time throughout the day to sit and talk with people in the lounges, seating areas in corridors and visiting people in their rooms. Some conversations were light hearted and familiar and this was appreciated. One person told us that they appreciated the varied relationships they had with different staff members.

We spoke with staff about people who could no longer communicate easily with words due to the impact of dementia. Staff explained how pictures were used to help people with some decisions such as what they wanted to eat. They were also able to describe how a combination of their facial expressions, movements and noises communicated how they felt and what they might need.

People and their relatives told us staff respected people's privacy and dignity. Staff knocked on people's doors before entering and did not share personal information about people inappropriately during our visits. We did, however, find a person's records in another person's room. We spoke with senior staff about this and this mistake was rectified immediately.

People's bedrooms were personalised with belongings, such as furniture, photographs and ornaments. People were encouraged to make decisions about their appearances, for example what they wished to wear. People appeared well cared for throughout our visits and staff supported them with their personal appearance.

Care plans reflected what people needed to retain their independence and the impact of staff support was evident throughout our inspection. People were calmly and patiently supported with their mobility. Staff were not rushed and could describe what parts of daily life people could undertake themselves and the individual support they needed. For example, a member of staff described how important it was not to rush a person due to the nature of their health condition. This information was in the person's care plan.

We heard about support for people's personal relationships. Senior staff identified that expression of sexuality was supported by the provider's policies required staff to work in ways that respected people's human rights and promoted equality and that staff had all received training on this.

Relatives told us that their relationships were supported and that they were made to feel very welcome. We heard about one family who lived a long way from the home being able to stay over the holiday period so that they could spend it with their loved one.

Requires Improvement

Is the service responsive?

Our findings

People expressed varied views about the care they received. Most people spoke positively about the care and made comments such as: "I could not fault the care – the attention is faultless and excellent." Other people identified that they were not always helped with things they needed.

Care plans had mostly been reviewed and covered a range of areas including mobility, communication and nutrition and hydration. They were individualised with some information about people's likes and dislikes and referred to people who were important in people's lives. Where care plans had not been reviewed recently the manager and deputy were aware of this and had a plan in place to review. Care plans did not, however, always correspond with the care people received. Staff described people's needs without judgement and emphasised people's individuality in all their discussion with us. Their understanding did not always reflect the information contained in the care plans. This meant people did not always receive care that was responsive to their needs.

Three people needed to do exercises that were designed to reduce the impact and progression of their health conditions. They told us that these did not always happen. One person said: "They are so busy they don't do them every day." Conversations with staff and records kept reflected that these exercises did not happen as stipulated in their care plans.

We spoke with the senior management team about this and they told us they would address the issue immediately.

Another person told us they had needed to complain to ensure they had appropriate continence products as staff had not been responsive to their requests which had left them nervous of having inappropriate protection and feeling undignified. They told us that once they complained the situation had been addressed to their satisfaction.

When we first visited a person was receiving end of life care, we noted that their door was open onto a noisy corridor and a commercial radio station was on playing modern music. We asked if this would be this person's wishes. Information about the person's preferences for the environment at this stage of their life was not recorded and we asked senior staff if this reflected their likes and preferences. When we returned to the home the music playing was more gentle classical music.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where care plans had been updated the reasons for the change were not always recorded. This meant it was not possible to monitor people's changing needs. For example, one person's care plan detailed a change in how often they needed support to move but this was not explained, nor was it clear when this undated change had been made.

There was ongoing work to ensure that people had meaningful things to do with their time. There were activities organised in the home every day of the week. Newspapers were delivered every day and we saw people spending time in communal areas reading these. A singing group for preschool children joined people, who enjoyed this, once a week. A local history event had enabled people to research the history of their home. A 'Wishing Well' programme provided a chance for people to identify something they would like to do and these had been arranged for people. Examples we saw included: a fish and chip supper by the harbour, a swim and a virtual tour was arranged for someone who wanted to go to France but couldn't due to ill health. The home was on a yearlong 'cruise' of the world with activities taking place and food provided to reflect the 'ports' they docked in. Regular captain's table events afforded people, relatives and staff the opportunity to eat together with senior staff as part of this 'journey'. We heard that people enjoyed these meals.

People's communication needs were identified at assessment before people moved into the service. These were recorded in the care plan so staff had information about people's needs. We saw that different forms of communication were explored with people including verbal, pictorial and using objects to communicate. People's communication needs were not flagged on handover information which meant temporary staff may not have the information they needed to best assist people to communicate their views.

We recommend you review your system of recording and sharing people's communication needs to reflect the Accessible Communication Standard.

There was a system in place for receiving and investigating complaints. People and relatives confirmed they knew how to make a complaint although some people felt they hadn't been asked if they were happy with the care they received. For example, one person told us that they perceived a member of staff as being bossy. When asked if they had raised this they told us: "No. No one has ever asked."

Complaints raised had been addressed in a transparent manner and within the timescales laid out in the provider's policy. Where learning needs were identified it was clear that this had been acted on with individual staff members.

Requires Improvement

Is the service well-led?

Our findings

The home had been through a period of unsettled leadership since registering with CQC in August 2016. The new manager had been appointed and they were in the process of applying for their registration. People told us they had been kept informed about leadership changes and spoke positively about the manager. One person told us they were confident that currently: "there is good leadership" and gave examples of concerns that had been addressed when the new manager was made aware of them. Relatives, also spoke highly of the senior team, commenting on their availability and responsiveness. They told us they could comment on all aspects of the service with confidence.

In the absence of a registered manager the provider had maintained close oversight of the service. Whilst this oversight had not been effective in addressing the issues highlighted during our inspection, the staff were positive about the arrangements and told us they had felt, and did feel, supported. One member of staff said: "We are a happy team". Other staff commented on the accessibility of management.

The registered provider had a quality assurance process that included regular provider visits to the home. The manager and senior staff also undertook audits. We found that these had not been effective in addressing issues identified; some of these had also been identified by other stakeholders prior to our inspection. For example, ongoing medicines errors had also been highlighted by an external audit in April 2018. The failure to act within the framework of the MCA; and the need to ensure that care delivery reflected care plans related to supporting people's skin to be healthy and had been identified during successive monitoring visits by the local authority dating back to August 2017.

Where the need for action was identified internally this did not always lead to appropriate action. Issues around recording had also been identified by senior staff in March and April 2018 but this was not being effectively addressed and monitored and as a result we found that records were not accurate or complete and this put people at risk of receiving unsafe care and treatment. Adverse incident recording detailed three incidents of choking in the year prior to our visit. This had not led to a safe and effectively communicated response to this risk within the home. A care plan identified as out of date in April 2018 had not been updated.

There was a resident of the day system in place but this had not been successful in ensuring people's care plans were up to date and that the care they received reflected that described.

The manager outlined a new system for monitoring record keeping and work had begun on ensuring the MCA was adhered to during our inspection. We have not been able to check the sustainability of this oversight.

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

The manager and provider representatives were visible within the service so were aware of day to day issues

brought to their attention by staff. People reacted with familiarity to them and this was reciprocated. The senior management they described how some staff had taken on 'pacesetter' roles within the team. These staff received support and training to champion the values and goals of the provider organisation and promoted positivity amongst the staff team. This approach was effective and people reflected on the cheerfulness of staff.

Staff spoke highly of their colleagues and told us they were all motivated to do the best for people. The staff team was continuing to develop and the manager told us that they had focussed on supporting and promoting a strong cohesive team since joining the organisation. Staff satisfaction had improved in this time as reflected in surveys.

The service had a clear management structure with senior staff working within the home and the manager reporting to their line manager from the provider organisation. The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications, had been complied with.

Records were typically stored securely and there were systems in place to ensure data security breaches were minimised. Staff had individual access to computer based records and rooms containing records were locked when not occupied by staff.

The senior team were open in response to inspectors and we saw that they identified opportunities for learning and shared these with staff and relevant professionals. There was a culture of openness evident in their actions and in the way staff communicated with each other. Staff told us they would be confident to whistle blow if this was necessary.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that reflected their needs or preferences. There was a breach of Regulation 9 (1) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's care and treatment was not always provided within the framework of the MCA. Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines as prescribed and people were at risk of not receiving safe care and treatment because staff did not record and communicate their needs. There was a breach of Regulation 12 (1) (2) (b) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

Quality assurance systems had not been effective in identifying the failure to ensure safe care and treatment to people. Records held about people's care were not accurate or complete. Information from professionals had not been used to improve the safety and quality of people's care
Regulation 17 (1) (2) (a) (b) (c) (e) (f)