Amore Elderly Care (Wednesfield) Limited

Bentley Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 09 and 18 July 2018. Bentley Court Care Home is a care home with nursing. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

This inspection was prompted in part by a notification of an incident when a person using the service died. This incident is subject to an investigation and as a result we did not examine the circumstances of the incident. However, as part of this inspection we looked to see if the risk to other people because of this incident had been mitigated.

Bentley Court provides care and support for up to 77 older people who require nursing or personal care, and who may be living with dementia. On the days of the inspection 69 people were living at the home. Bentley Court has two independent units. The ground floor provides nursing care to people and the first floor provides nursing care to people primarily living with dementia.

Since our last inspection the home has a new registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although staff knew people's risks care records were not always up to date or reflective of people's needs. During day two of our inspection the provider had acted to ensure there were sufficient numbers of staff available to meet people's needs. People told us they felt safe and staff understood their responsibilities to raise concerns regarding potential abuse. People told us they received their medicines as prescribed. People were protected from the risk of infection.

Not all staff had the skills and knowledge to meet people's care and support needs. Staff lacked knowledge about which people were subject to a Deprivation of Liberty Safeguards [DoLS] and the application of DoLS by the provider was not effectively maintained. Staff missed the opportunity to engage with people as they were often focussed on tasks. People received adequate amounts of food and drink. We saw evidence people were supported to access healthcare professionals when required. People were not always treated with dignity and respect.

People had access to some activities. Care records were not reflective of people's needs. People knew how to raise concerns or complaints and the provider had a system in place to investigate concerns.

The provider's quality assurance systems were not always effective at identifying and addressing issues of concern that may affect people's safety. People's feedback in relation to the quality of the service was being sought. The registered manager understood their responsibilities for reporting incidents or events that

occurred at the service to CQC. People and staff were positive about the new registered manager and said they were open and approachable.

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

Risk assessments were not always reflective of people's needs. Sufficient staff were available on the second day of our inspection to meet people's needs. People received their medicines on time and were protected from the risk of infection. People were protected from the risk of harm or abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider was not effectively following the principles of the MCA to ensure people that lacked the mental capacity to agree to their care were supported in their best interests. Not all staff had the skills and knowledge to meet people's needs. People received sufficient amounts of food and drink and had access to healthcare professionals as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive care that respected their dignity and privacy. People did not always receive care based on their preferences because staff were often busy and task orientated.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not always reflect people's current needs and were not up to date. People and the relatives knew how to complain and felt listened to. People were supported to maintain relationships with family and friends.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The systems and processes in place to assess and monitor the safety and quality of the service was not always effective. People

and staff felt the new registered manager was open and approachable and said they could share their views on areas of improvement.

Bentley Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was prompted in part by a notification of an incident following which a person using the service died. This incident is subject to an investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of choking and the use of 'Do Not Attempt Resuscitation' (DNACPR). This inspection explored whether the risk to other people had been mitigated against. As part of the inspection we also looked at the information we held about the service. This included notifications the provider must send us to inform us of certain events. We also contacted the local authority for information they held about the service. This helped us plan our inspection.

The inspection took place on 09 and 18 July 2018 and was unannounced. On the first day of the inspection the inspection team consisted of two inspectors, one pharmacy inspector, one assistant inspector and one expert by experience. The expert by experience was a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection the team consisted of one inspector.

During the inspection we carried out observations of the care and support people received. We used the Short Observational Framework for Inspection (SOFI) to observe how care was provided to people who were unable to speak with us. We spoke with five people who lived in the home, six relatives, nine staff members, the registered manager and operational manager. We looked at records about people's care and support, staff files, medicine records and systems used for monitoring the quality of care provided including accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in October 2017 we rated the provider as 'Requires Improvement' in this key question. This was because we found improvements were still required in the management of medicines. Since our last inspection we had received several concerns from other agencies and relatives regarding people's care and treatment at the home. We used this information to plan this our latest inspection. As part of the inspection we looked at how the provider met people's individual needs and how they mitigated any risks to keep people safe. Although we found improvements had been made in relation to the management of medicines other areas of care had deteriorated.

Following day one of this inspection we asked the provider to address the immediate concerns we found, around managing people's risks and ensuring there were sufficient numbers of staff available to meet people's needs. We completed another visit to the home to confirm the actions the provider had taken were sufficient to alleviate the risks to people's health and wellbeing.

At our inspection in April 2017 we received mixed views whether staffing levels were adequate to meet people's needs. At our following inspection in October 2017 we found improvements had been made in relation to the numbers of staff available to support people. At this our most recent inspection we found improvements had not been sustained.

On day one of our inspection we found sufficient staff numbers were not available on the dementia unit to meet people's needs. People and their relatives raised concerns to us about the standard of care received. One person told us, "Sometimes there's no one about." A relative commented, "There is nobody about to ask anything." Another relative told us they were unable to find a member of staff to support their family member with their personal care needs and this had resulted in their dignity not being met. Staff we spoke with told us they were busy and felt there were not sufficient numbers of staff to meet people's health and care needs in a timely manner. One member of staff told us, "It does not feel safe. We are not meeting needs. We can't do everything." Our observations during day one of our inspection confirmed this; we saw people had to wait for their needs to be met, and on two occasions members of the inspection team had to locate staff to support people with their care needs. For example, we saw one person slip from their chair and observed a member of staff attempt to lift the person on their own; we intervened and found other members of staff to help manoeuvre the person safely back into their chair. On other occasions we found staff were not available in communal areas of the home to respond to people's requests for help. One person we saw indicated to the inspection team they required support. We spoke with a member of staff who said they would attend to the person's needs; it took a further 30 minutes until a member of staff had time to check what this person required. During this time the person became increasingly anxious. We found people's needs were not being effectively met and they were exposed to the risk of harm due to insufficient numbers of staff available to meet their needs.

As a result of the concerns we raised with the management team following day one of our inspection; the provider deployed an additional staff member to the dementia unit and divided the unit into two allocating specific staff on each. On the second day of our inspection we checked to see if the actions the provider had

taken were sufficient to mitigate any risks to people. One person we spoke with told us, "I get my needs met the staff are busy but they help me when I need it." A member of staff said, "The extra member of staff allows us more time to help people and having the unit split into two makes it much more manageable for [staff]. Its more settled and calmer it's such an improvement it feels better and people are safe." Another member of staff told us, "The extra member of staff means people who need extra support or might become distressed get attention." Our observations confirmed what we had been told that there were adequate numbers of staff available to meet people's needs. We saw there were enough staff to give people the care they required and to respond to situations or incidents that occurred. For example, we saw one person who became agitated, and saw a member of staff sit with this person until their anxiety decreased. On another occasion we observed a member of staff sitting and encouraging a person with their meal.

We spoke with the management team and they confirmed that staffing levels had been increased by one member of staff. They said it was their intention that this would continue in order to meet people's needs in a timely manner. They said they were also reviewing the layout of the units to improve the quality of care people received. Although the provider had responded quickly to our concerns regarding staffing levels being sufficient we will continue to monitor the service to ensure the improvements have been sustained and embedded into practice.

Prior to the inspection we received a notification about the death of a person who lived at the home. At the time of this inspection this was being investigated by partner agencies. However, based on the information we had we looked at how people's risks were managed around choking and the staff's understanding of the use of 'Do not Attempt Resuscitation' (DNACPR). All the staff we spoke with said the management team had discussed with them the meaning and use of DNACPR and the actions they should take. Staff also said they had attended first aid training and explained the actions they would take if someone was found choking.

At our previous inspection in October 2017 we found staff were aware of the risks to people's health and wellbeing to ensure their safety. At this inspection we found during day one of our inspection although staff were aware of people's risks those we spoke with had inconsistent knowledge of what action they might take to mitigate any risk of harm. For example, staff were not always aware of how to keep people safe when they displayed behaviours that challenged. One member of staff we spoke with told us about a person's triggers and the actions they took to reduce this risk when the person became agitated. A trigger is something that sets off a memory transporting the person back to an event or time which might have caused them distress. Other staff we spoke with were not clear about this person's triggers and what they might do to manage these. We looked at this person's risk assessment and found it did not give sufficient guidance for staff to refer to, to ensure the person received appropriate care.

On the second day of our inspection staff explained the dementia unit had been split into two and staff were allocated to one of the two units. Staff said this had had a positive impact upon people's safety because they had more opportunity to spend time with people and develop their understanding of people's individual risks. We saw examples where risks to people had been minimised. For example, we saw staff had contacted the doctor and arranged for a person's fluid intake to be reviewed. We also saw information in people's care records had been updated to reflect their current needs. For example, in relation to falls. We saw that the necessary improvements required from day one of our inspection had been made.

At our last inspection in October 2017 we found improvements continued to be required in some areas of medicine management. At this inspection we found there were systems in place so that people received their medicines as prescribed. One person told us, "I get my medicines at fixed times I am happy with that."

Some people's medicines were prescribed on a 'when required' basis; we found some guidance for these

medicines lacked detail as to when they should be given. Other written information about people's individual needs for the administration of their medicines was not always up to date. For example, at our last inspection we found where people had their medicines disguised in food or drink no written information was in place to inform staff how to do this safely and consistently. At this inspection we found improvements were still required. Best interest's procedures for the administration of medicines to people who lacked capacity to make an informed decision were not always up to date or clear.

We looked at Medicine Administration Records (MAR) for 22 people and found they were completed correctly. We found people who required their medicines at a specific time to manage health conditions received them when required. We also found guidance was available for staff to refer to in relation to safely applying medicines via skin patches on a person's body.

Medicines were stored and disposed of safely. We found fridge and room temperatures were being recorded daily and medicines were stored within safe conditions. There were suitable arrangements for storing and recording medicines that required extra security.

People told us they felt safe living at the home. One person said, "[Staff] make it safe." A relative commented, "The whole place is safe." Staff we spoke with demonstrated a good understanding of their role in protecting people from harm and knew how to escalate any concerns or issues they might have in relation to people's safety or well-being. One member of staff told us, "I would tell the manager or nurse straight away if I thought someone was at risk of abuse or harm. They would report it to make sure the person was safe." Staff told us and records we looked at confirmed they had received training in identifying possible signs of abuse and the actions that should be taken. The new registered manager was completing retrospective investigations into some incidents that had not been fully investigated at the time they occurred full stop They were also developing and embed systems to recognise and report incidents of abuse. Records we looked at showed the local authority and CQC were being informed of incidents as legally required.

People and relatives, we spoke with had mixed views about the cleanliness of the home. One person said, "It's alright here, it's clean." A relative commented, "The cleanliness of the place isn't up to par. I don't know whether the rooms are cleaned often enough." Staff told us they had access to personal protective equipment (PPE), we saw this was available throughout the home and observed staff using it. We saw staff washed their hands and used gloves and wore aprons when needed. Communal areas of the home we saw were clean and tidy. We were invited into some people's bedrooms and found these to be clean and well-maintained. We saw audits were completed and cleaning schedules were in place to ensure the cleanliness of the home.

We looked at the recruitment process in place to check the suitability of staff to work with people. Reference, identity verification and Disclosure and Barring Service (DBS) checks had been completed to ensure new staff had been recruited through safe recruitment procedures. DBS checks helps providers reduce the risk of employing unsuitable staff. This showed the provider had adequate systems in place to demonstrate staff were suitable to work within a care service.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in October 2017 we rated the provider as 'Requires Improvement' in this key question. This was because people's opinions about the choice of food were varied. At this inspection, we found some areas of care had deteriorated which meant they were no longer meeting the requirements of the law.

At our last inspection we found people did not always have a choice of food or access to adapted cutlery to support their independence. At this inspection people told us they were offered a choice of meals however, views were mixed on whether they enjoyed the food offered. We found although people were asked for their meal preference by staff, some people did not understand and were not offered the opportunity to make food choices by visual or sensory prompts such as plated up menu options for them to view. Two people we spoke with said they did not enjoy their meal and another person said, "Food is okay."On day one of our inspection it was clear that there were not enough staff to assist or prompt people to eat their meal and as a result some people waited for long periods of time. On day two of our inspection we found improvements had been made to enhance people's meal time experience and staff were available to assist people with their meals as required.

On day one of our inspection we reviewed some records of people's dietary and fluid intakes and found information was not consistently recorded in the same place. This meant it was difficult for staff to be sure people had received enough to eat and drink to maintain their health. On day two of our inspection we found the management team had checked that people had received sufficient fluids to maintain their health. Staff we spoke with explained they monitored people's fluid intake throughout the day and pushed fluids where required. We saw one person who had not achieved their target for fluids and noted staff had referred them to the doctor for further advice. We saw special diets such as soft diets were catered for and there were utensils available to support people to eat and drink independently. This indicated people were supported to eat and drink sufficient amounts to remain healthy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people 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 home was working within the principles of the MCA and if any conditions on authorisations to deprive a person of their liberty were being met. There were several people that had been deemed to lack the mental capacity to consent to their care and treatment and we found no applications had been made to the authorising authority to lawfully restrict them. For example, one person wore a zipped suit so they could not remove their clothing. This person's mental capacity had not been assessed in relation to this decision and the judgement had been made without any health or social care professional

involvement in the agreement to restrict this person's freedom. We saw another example of where a person's mental capacity had not been assessed in relation to a decision about the use of a stairgate on their bedroom door. We found a decision had been taken without following the best interests process. This meant that people's legal rights had not been upheld.

At our last inspection in October 2017 staff had attended training and demonstrated an understanding of the people subject to a DoLS authorisation and their role and responsibilities regarding MCA and DoLS. At this inspection although we found staff had received training in MCA and DoLS their knowledge was poor and they were not able to explain what this might mean for a person who was subject to one. Staff were also unable to identify who was currently subject to a DoLS authorisation or what this meant for how they provided care and treatment to them. This meant that the DoLS and requirements of the MCA were not implemented or understood by staff despite attending training.

On day two of our inspection the management team had acted and removed the restrictions placed on people who did not have an authorised DoLS in place; they also provided us with evidence that applications had been submitted to the authorising authority. Although the provider had responded quickly to our concerns; these shortfalls did not show that the registered manager and staff team understood and were implementing the MCA to ensure people's rights were upheld. We will continue to monitor the service to ensure the improvements have been sustained and embedded into practice. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people's individual needs were assessed at the point of admission into the home to ensure the service could meet their needs. Some people we spoke with could tell us that they were involved in the assessment and the planning of their support needs. One person said, "Staff involve me." However, the process to identify people's support needs required strengthening. We found although an assessment had taken place prior to people moving into the home it lacked detailed information about any diverse needs such as sexuality or culture. We also found some people living with dementia their specific needs in relation to their dementia were not always clear. For example, some people became anxious and the assessment process had not identified the things that might make a person anxious or the things that might help reassure them.

At our last inspection people and their relatives told us they felt staff had the right skills and knowledge to be able to support them. At this inspection we received mixed views whether staff were well trained. One relative said, "I have seen a few staff interactions with [person] I think they are well trained." While another relative commented that some staff would benefit from additional training to support those people living with dementia. Our observations supported this view. We observed one person continually trying to leave the dining room for a period more than ten minutes. We saw staff repeatedly encouraged them to sit down. We saw the person was persistently touching the back of their clothing and walking out of the room. Staff did not recognise the different ways people with dementia might communicate and as a result this person's personal care needs were not met until another member of staff intervened. On another occasion we observed a member of staff attempt to use an unsafe technique to assist a person who had slipped from their chair. Although the member of staff had received training they failed to follow the training they had received and exposed the person to the risk of harm. We spoke to the registered manager about staff training and they informed us that additional training had been identified for staff and this had been arranged along with observations of staff practice.

At our last inspection people told us their health needs were met and they had access to external professionals such as opticians and doctors. At this inspection we found people continued to have access to healthcare professionals when required. The new registered manager explained to us that they had

contacted appropriate external professionals such as a community psychiatric nurse (CPN), doctors and occupational therapy (OT) to ensure people's needs were being met appropriately. Staff we spoke with explained how they supported people with their needs. They said they worked with other professionals to ensure people's needs were met and followed advice given. We looked at people's care records and systems in place to support staff communication with both external professionals and between themselves. We were told and saw daily flash meetings took place with the registered manager and representatives from each staff team. Information was shared and any issues of concern discussed, including those about people's health or well-being. This enabled the registered manager and clinical staff to contact external agencies such as doctors to ensure people received safe care.

At our last inspection we found people did not always have a choice of food or access to adapted cutlery to support their independence. At this inspection people told us they were offered a choice of meals however, views were mixed on whether they enjoyed the food offered. Two people said they did not enjoy their meal and another person said, "Food is okay." We found although people were asked for their meal preference by staff, some people did not understand and were not offered the opportunity to make food choices by visual or sensory prompts such as plated up menu options for them to view. On day one of our inspection it was clear that there were not enough staff to assist or prompt people to eat their meal and as a result some people waited for long periods of time. On day two of our inspection we found improvements had been made to enhance people's meal time experience and staff were available to assist people with their meals as required.

On day one of our inspection we reviewed some records of people's dietary and fluid intakes and found information was not consistently recorded in the same place. This meant it was difficult for staff to be sure people had received enough to eat and drink to maintain their health. On day two of our inspection we found the management team had checked that people had received sufficient fluids to maintain their health. Staff we spoke with explained they monitored people's fluid intake throughout the day and pushed fluids where required. We saw one person who had not achieved their target for fluids and noted staff had referred them to the doctor for further advice. We saw special diets such as soft diets were catered for and there were utensils available to support people to eat and drink independently. This indicated people were supported to eat and drink sufficient amounts to remain healthy.

New members of staff completed an induction to ensure they had the knowledge required to support people. One member of staff said, "I had an induction and shadowed other staff. I also did a lot of training [for example] safeguarding and moving and handling." Staff who were new to the care sector were required to complete the care certificate which is a set of standards aimed at developing staff's skills and knowledge enabling them to provide safe care to people. Staff also confirmed they had completed training in other areas such as mental capacity and infection control. They explained they felt supported in their roles and received one to one meetings with their manager which provided an opportunity to discuss their role and any training needs.

The home environment met the physical needs of the people who lived there and it was pleasantly decorated throughout. We saw the home had signage to navigate the building which assisted those people living with dementia to find the bathroom and their bedroom; as well as having flat floor surfaces and grab rails which enabled people to mobilise independently and safely around the home. The registered manager also told us they were looking to move the dementia units down stairs to facilitate more active people opportunity to access the garden.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in October 2017 people spoke positively about the staff who supported them and we rated the provider as 'Good' in the key question of 'Is the service caring?'

At this inspection people continued to say they thought staff were caring. One person said, "Staff are very nice." A relative commented, "I don't know anywhere else [person] would get this level of care." During day one of our inspection although we saw some positive interactions with people, staff were often task focussed because of the constraints on the numbers of staff available. We observed staff were very busy particularly on the dementia unit and as a result had limited time to sit and talk with people who were distressed or anxious. For example, we observed a person who became agitated because of the noise another individual was making. We saw this person appeared to be troubled by the noise and observed a member of staff explain the behaviour was not deliberate. However, the person became increasingly anxious and shouted, "Get rid of the noise, I don't care make [person] stop." Research suggests that high levels of noise can trigger some people diagnosed with dementia to become anxious and agitated. Staff did not consider this person's or other people's needs when seating people for their meals where there were raised noise levels. As a result, this person was exposed to unnecessary distress. Staff told us they were busy completing care tasks and this impacted on the quality of care people received. We found the provider's systems did not ensure people were supported in a caring manner and staffing arrangements in place impacted on the quality of care people received.

During day two of our inspection staff told us they had more time to spend with people because they were allocated to specific units. They said they had time to stop and respond to people who appeared to be agitated or upset. For example, we saw a member of staff sitting with a person who became anxious. We observed they spent time talking to the person until they became calmer. We saw another occasion where one member of staff was supporting a person to eat their meal and observed they spent time talking to the person and offering encouragement. Although we saw a positive improvement from day one of our inspection we will continue to monitor the service to ensure the improvements have been sustained and embedded into staff practice.

Although people told us staff respected their dignity and privacy we saw on the dementia unit several people in a state of undress in their bedrooms with their doors open and on view to any passing visitors. We also saw one person had been incontinent and staff could not be found to support them. This was not dignified for people and we brought it to the attention of staff who acted to address the issues. We saw other examples, where people's dignity was not always maintained. We saw one person walking around the communal area in a state of undress, we alerted staff who responded immediately to support the person to become appropriately dressed. Another example, a person required the use of equipment to transfer from chair to chair. We saw the person's clothes had risen through their movement which meant they were exposing the lower half of their body. Staff did not cover the person's lower body to maintain their dignity. Our observations on the first day of our inspection visit concluded that consideration had not been given to the staffing numbers deployed to account for people's needs and the size and layout of the dementia unit which meant people's dignity was not promoted. When we returned on the second day staff had been

allocated to separate units this meant staff had fewer people to look after and ensured people's needs were responded to quickly and their dignity was maintained.

People we spoke with told us as far as possible they were involved in everyday decisions about their support needs. One person told us they could choose when they went to bed or got up. However, we saw throughout day one of our inspection staff were often rushed and therefore task orientated. This meant some people did not always get a choice of what they would like to do or where they spent their time. For example, we saw one person who left the lounge area being approached by a member of staff and asked to go back into the lounge. It was unclear why this person was asked to go back into the lounge and not go independently to other areas of the home. We saw another person who was at a high risk of falls and had a sensor mat placed beside their bed to alert staff when they were attempting to get up. Staff responded to the person when the alert went off however the person was asked to stay in their room and not offered the chance to mobilise with staff because there were not enough staff available to support this person's needs. Care records we looked at contained some individual information about people's choices and preferences that were important to them. This information would support staff to provide personalised care but due to the constraints of staffing people did not always get their choices met.

Relatives we spoke with told us there were no restrictions when visiting their family member. One relative commented, "I try to visit most days." We saw throughout the inspection visitors arriving at the home were greeted and made to feel welcome by staff who knew them by name. People living at the home were supported to maintain contact with their family and friends.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in October 2017 we rated the provider as 'Good' in the key question of 'Is the service responsive?' We found people were supported to take part in a range of activities and the environment of the home had been improved to stimulate people's interest. At this inspection we saw the running of the home was based on tasks and routines and people's choices were sometimes limited.

People we spoke with had mixed views whether they had been involved in discussions about their care. One relative said, "I was involved in developing the care plan and staff do contact me if they have any concerns." Other people and their relatives told us although they had been asked about their care needs when they came into the home they could not recall any further meetings taking place. The new registered manager told us they had identified that some people's care records needed to be reviewed so that they were reflective of people's needs. They continued to explain although there was a process in place to review one person's record each day this had not always occurred; this meant information was not always updated when changes in people's needs had occurred. This reflected what we saw, care records did not always contain sufficient detail about how people wished their care to be delivered and information about people's personal histories, likes and dislikes were not always recorded. On day two of our inspection several people's care records had been reviewed, and others were in the process of being reviewed and updated by the management team. The new registered manager said this was to ensure information within the care records were accurate and risk assessments were reflective of people's needs. We looked at the newly developed care records and found they included information about people's individual risks and care needs along with offering guidance to staff. Staff told us information was shared with staff about people's changing needs during shift handover and daily meetings and this ensured people received care that met their individual needs. This system needs to be further developed and embedded to ensure that changes to peoples needs are met in a timely way.

We received mixed responses from people and their relatives about the activities and hobbies on offer. One person said, "I like to watch what's going on, I don't take part in the activities." A relative commented, "There are artists that come, it's great they do a lot of activities here." The home had two activities co-ordinators who organised different activities each day for people to take part in. These included one to one activities with people such as reading and chatting about recent events. During the inspection we observed people were offered the opportunity to take part in several different activities throughout the day for example, we saw one person being encouraged to look through a book and other people being supported to take part in art and craft activities. We also saw other people, enjoyed sitting and chatting with family members.

People and their relatives knew how to raise a complaint if they were unhappy about the care they received. One relative commented, "If there is anything that needs sorting out they do it instantly." Relatives told us they would speak to the registered manager or staff if they had any concerns. We found complaints were being responded to promptly by the registered manager and each complaint was reviewed to see if there were any lessons to be taken from the issues raised. Staff we spoke with were confident to address minor concerns that were raised directly with them by people or by their relatives or visitors. The registered

manager also advised us of their intention to introduce a system that would facilitate the identification of any trends, patterns or reoccurrences to improve the quality of care received.

At this inspection one person was receiving end of life care. Conversations with staff and records we looked at reflected preferences and wishes in relation to end of life care. This inspection was prompted in part by a notification of an incident which raised concerns about staffs understanding of and the use of 'Do Not Attempt Resuscitation' (DNACPR). This inspection explored whether the risk to other people had been mitigated against. We found where people had expressed a wish not to be resuscitated the records relating to this were available to staff to refer to. Conversations we had with staff demonstrated they understood when a DNACPR should be applied.

Requires Improvement

Is the service well-led?

Our findings

The overall rating for this service remains as 'Requires Improvement' as it has been for the past three comprehensive inspections. This means that the provider has been unable to implement sustainable improvements to the care and support people receive. The home has had a turnover of managers since 2016 and this has resulted in the lack of stability for staff and people living at the home. A new registered manager had been appointed and they have worked alongside the operational manager over the last three months to provide stability to the home and were in the process of reviewing and implementing quality assurance processes to address the concerns we found during our inspection. The registered manager told us the issues we highlighted to them were things they were aware of and were in the process of trying to address. It was clear from the inspection that work continued to be required to bring the quality of the service provided to people to the minimum standard of 'Good' and to be able to sustain that level.

At our last inspection in October 2017 we identified the service had continuing governance concerns and had failed to provide the necessary evidence that the service was well led. At this inspection we found the systems in place to monitor the quality and safety of the service had not always been used effectively to implement improvements where issues had been identified. This was evident from some of the concerns we found during the inspection. We found the systems to monitor incidents and accidents for patterns or trends required improvement to mitigate any risk of reoccurrence. We also found systems to evaluate staffs' skills and understanding of people's needs required improvement particularly around ensuring people's legal rights were promoted. Systems to identify that there were sufficient staff deployed to meet people's needs also needed improving to ensure people remained safe. Systems to check care records also required improvement to ensure they were reflective of people's needs and contained sufficient guidance for staff to refer to.

Following the first day of our inspection we asked the provider to send us an action plan stating how they were going to improve the care people received to ensure it was safe, effective, caring and responsive to their needs. We returned to the home for a second day's inspection to check whether sufficient action had been taken to address the areas of concern we identified. We found the management team were continuing to develop and improve the quality assurance systems to monitor and assess the standard of care people received. We found the registered manager had introduced a process which allowed them to have management oversight of incidents and accidents which meant care records could be reviewed in response to people's needs.

We found although improvements had been made in relation to the systems and processes in place to assess, monitor and mitigate the risks to the health, safety and welfare of service user's. We could not be assured that processes were fully implemented and embedded into staff practice and were effective because they had not proactively identified the concerns we found during our inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.agreed

Since our last inspection a new registered manager had been appointed in May 2018. The new manager understood their responsibilities as a 'registered person' for reporting certain incidents and events to CQC

and to other external agencies that had occurred or affected people who lived at the home. They also ensured the rating that was given to the home by CQC was displayed.

People and their relatives knew the management structure of the home and said that they had noticed an improvement in the running of the home since the new registered manager had been appointed. They said they knew who the registered manager was and felt they could approach them if they had concerns. People and their relatives told us they had been invited to attend a meeting and their feedback about the home was being sought. One relative said, "I know there is a resident and families meeting." Another relative told us although they had not attended a meeting they had been asked to complete a form about the quality of care their relative received. This demonstrated the provider was taking account of people's views to improve the quality of service provided.

Staff we spoke with told us they were aware of their roles and responsibilities and expressed positive views about the new registered manager and said they were open and approachable. One member of staff said, "After [day one of the inspection] the manager met with us all and explained the findings and what they were going to do to address the issues [CQC] found." Staff told us they felt confident to make suggestions or offer ideas for improvement to the management team and said staff worked well together. Staff were aware and demonstrated their understanding and awareness of the provider's whistleblowing procedures. Whistle blowing is when a staff member reports suspected wrongdoing at work. Staff said they felt confident that if they raised any concerns the registered manager would listen and take the appropriate action.

We saw evidence to support the service had worked in partnership with other organisations such as healthcare professionals. We also found the registered manager and operations director was responsive on the days of our inspection, taking actions to implement change following feedback of our findings to show continuous improvement.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not always following the principles of the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Some of the providers systems to monitor and improve the service had not been effective.