GCH (Alan Morkill House) Limited

Alan Morkill House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 and 31 March and 3 April 2017 and was unannounced on the first day.

At our last comprehensive inspection on 5 April 2016 we rated this service "Requires Improvement" and found breaches of regulations relating to safe care and staff training. We carried out a follow up inspection in December 2016 and found that the provider had made some improvements but was still not meeting these requirements. We received concerns about the quality of care provided by the service and brought forward this scheduled inspection in order to look into these. At this inspection we rated the service "Requires Improvement".

Alan Morkill House is a care home for up to 49 older people and people with dementia. There is a large kitchen and communal lounge on the ground floor and a shared courtyard and garden, and each floor includes a communal lounge, kitchen and dining room. The service is divided into seven units, three of these units provide care for people with dementia. At the time of our inspection there were 39 people using the service.

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

We found that the building was not always safe and potentially unsafe issues with premises were not always addressed in a timely manner, for example kitchens and cupboards storing cleaning materials were left unlocked. Although staff carried out checks of water temperatures and fridge temperatures, there were not always clear guidelines in place, and in some cases people were bathed in water which was too hot, which was not checked by managers. Where people were at risk of pressure sores, turning charts were not correctly completed or checked. Medicines were not managed safely, and we found that in many cases people did not receive their medicines as prescribed. Managers did not carry out sufficient checks to detect these issues.

Call bells were checked to ensure that they were operational, and these were responded to promptly, although staff could not always hear these in some areas of the building. Units for people living with dementia did not use dementia friendly design to aid people's orientation around the building. We have made a recommendation about this.

The provider had assessed people's capacity to make decisions, but did not always review these regularly, and when people were deprived of their liberty in their best interests the provider had acted lawfully. However, the provider did not ensure that people had appropriately consented to their care.

Staff training had improved, but some staff had not received training in mandatory areas, and the provider

did not have a clear assessment of the training needs of the service. Many staff did not receive regular supervision and team meetings were not well attended enough to ensure good communication.

People received good support at mealtimes and food was nutritious and varied, however recommendations from dietitians were not always followed, and people's weights were not audited in a way which would detect and address weight loss. Where people required food and fluid charts these were not always correctly completed or checked by managers.

People's needs were assessed and reviewed regularly, and people's wishes and preferences were identified by staff, including their wishes for the end of their lives. We found that people benefitted from caring and attentive staff and from a varied and interesting activity programme.

People told us they were treated with respect by staff and we observed friendly and caring interactions. Staff worked to maintain a suitable and friendly environment for people. Staffing levels were not unsafe, but staff told us they felt stretched at times. Managers addressed complaints effectively, and took appropriate action against staff where poor practice had taken place. The provider carried out appropriate pre-employment checks to ensure staff were suitable for their roles.

We found breaches of regulations regarding safe care, medicines, staff support, consent, nutrition and good governance. We issued a warning notice in relation to safe care and the management of medicines. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

Medicines were not safely managed or checked.

The premises were not always safe, and the provider did not fix potentially dangerous issues in a timely manner. Some safety measures such as turning charts and water temperatures were not adequately carried out to protect people from harm.

Staffing levels were sufficient to keep people safe.

The provider carried out suitable pre-employment checks on staff.

Is the service effective?

Requires Improvement

The service was not effective in all respects.

There was a training programme in place, however a small number of staff lacked mandatory training, and the provider had not assessed the training needs of the service. Some staff did not receive regular supervision.

People were well supported to eat, however when people were at risk of malnutrition, food and fluid charts were not correctly completed. People's weights were not monitored in a way which would allow staff to detect weight loss.

The provider maintained a balance between people's freedom and safety, but did not always obtain appropriate consent to people's care.

Is the service caring?

Good

The service was caring. People were treated kindly and respectfully by staff and were positive about their care workers.

Care workers showed consideration to maintaining a pleasant environment for people, worked to start conversations and provided reassurance.

People and their relatives were supported to speak up through regular meetings, and the provider had sought people's views on their wishes and preferences, including at the end of their lives.

Is the service responsive?

Good

The service was responsive. People benefitted from a varied and interesting programme of activities.

People's needs were assessed at the time they joined the service and care plans were comprehensive in their scope and reviewed regularly.

People were able to make complaints to managers and these were responded to appropriately.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

Audits were not carried out regularly by the registered manager and there was insufficient checking of important safety and nutritional checks to detect issues with these.

Confidential information was not stored securely and was often left unattended. Team meetings were not well attended, and some staff told us they were not listened to.

External audits were effective at identifying issues, and in many areas there were plans in place to address these.

Alan Morkill House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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. We brought forward this planned inspection as we had received information of concern about this service.

This inspection took place on 29 and 31 March and 3 April 2017 and was unannounced on the first day. On the second and third day the provider knew we would be returning.

On the first day, the inspection was carried out by two inspectors, a specialist professional advisor who specialises in medicines and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second and third days the inspection was carried out by a single inspector.

Prior to carrying out this inspection we reviewed information we held on the service. This included information on significant events that the provider was required by law to tell us about and complaints and concerns we had received about this service. The provider had also written to us to tell us how they were going to address breaches in legal requirements we found at our last inspection.

In carrying out this inspection we spoke with 11 people who used the service, two relatives and a visiting professional. We spoke with the registered manager, regional manager, deputy manager, administrator, activities co-ordinator, a senior care worker and seven care workers. We reviewed records of care and support relating to seven people and records relating to the management of 24 peoples' medicines. We looked at the personnel files of five staff members and looked at records of training, supervision and rotas for the entire service. We also looked at health and safety checks and records of complaints and audit.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found that the provider was not checking water temperatures before carrying out personal care. At this inspection we found that this was now taking place, however temperature recording charts lacked clear guidance for staff on what was a safe temperature. The provider told us that showers should not be hotter than 41 degrees, however records showed that shower temperatures for one person had exceeded this by up to one degree, and that on one occasion a person had been washed with water at 46 degrees. Health and Safety Executive Guidance states that there is an increased risk of scalding when people are showered or bathed in water above 44 degrees Celsius. This showed that staff were not aware of safe temperatures for bathing. The temperatures of all water outlets were recorded by maintenance staff on a monthly basis; this included clear guidelines for staff and where temperatures were significantly hotter we found that action had been taken to address these.

There was a system of locks in place to protect people's safety. The front door was kept locked, and could only be accessed by entering a code, and people were only able to leave the units upstairs by entering a code, which was given to people who were able to leave the service alone safely. Where people were not able to leave units, these restrictions were put in place in people's best interests and appropriate assessments had been carried out. Kitchens were also protected by a lock, however we found that the lock on the first floor kitchen was broken, which meant that people were able to access this kitchen without staff support. On the second floor this was left unlocked on the first day of our visit. In both kitchens, cupboards containing cleaning chemicals were left unlocked. Although the provider told us it was their policy to keep these cupboards locked and arranged for a contractor to visit to rectify the faulty door, we were able to access the first floor kitchen and cupboard on the final day of our visit. It was discussed in the team meeting in January 2017 that kitchen doors were broken, but two months had elapsed since this issue was first noted.

We saw that where people were at risk of pressure sores, these risks were not always managed appropriately. For example, one person's care plan stated that they needed to be turned every two hours. The provider maintained charts to monitor this, however we found that these were not always in place, and were not always dated. The provider required turning charts to be signed off by a senior member of staff, however this was not taking place. This meant we couldn't be certain that the provider was taking appropriate steps to manage this risk, although records maintained by the district nurse showed that the person's pressure sore was healing. We found that the provider carried out audits of where people may be at risk of developing pressure sores, however these audits were not always dated, so it was not clear that these were taking place regularly.

Medicines were not always safely managed. The provider maintained Medicines Administration Record (MAR) charts for administering prescribed medicines. We saw that there was information on people's allergies, however this had not been completed for people who had recently moved into the service.

We looked at the recording of receiving and administering medicines for 24 people. For one person, we saw that there were two MAR charts in operation for them in different parts of the medicines folder, and that on

one day it was recorded they had received their medicines twice. For some people there were no dividers between their MAR charts and no cover sheet with the person's photograph, which meant there was a risk of the wrong person receiving medicines. We noted overall 29 omissions in recording administration of medicines.

Receipts of medicines and quantities carried forward from one cycle to the next were not always recorded so it was not possible to carry out audits for these medicines. A patch for pain relief was not recorded as applied on a particular day, but we could see that this had been administered from the register of controlled drugs. A weekly medicine was not recorded as given and there was not enough of this medicine in stock for the rest of the medicines cycle. One medicine was not recorded as given for four days, but our audit of this medicine indicated that this was not administered on three occasions. For another medicine we found that this had not been signed for on seven occasions, and although the instructions stated this was to be administered four times a day the MAR was altered to three times per day. We saw no evidence of the prescriber having changed the dose.

For a medicine for diabetes, we saw that on three occasions this had not been signed for. A count of the remaining stock indicated that these three doses had not been administered, and that a further three doses had been signed as administered but had not been given. This same person received an anti-psychotic medicine, however they had not received this on four occasions in the past month. For two people who were prescribed patches, there were no charts in place to map where these had been applied.

All medicines were stored safely in locked clinical rooms and trolleys. There were records of fridge temperatures and of storage rooms to ensure that medicines were stored at suitable temperatures. Medicines should be refrigerated between 2 and 8 degrees Celsius. However, one fridge had been reading 2 degrees for several weeks and on the day of inspection was indicating the temperature was "low". Records showed that the temperature of one medicines fridge was recorded on several occasions as 0.2 or 0.3 degrees, however there was no evidence that this was followed up, and temperature charts were not always checked by managers.

In total, we carried out 23 stock counts of medicines and found that six of these were incorrect, which meant that people did not receive their medicines as prescribed. We saw several other omissions in recording receipts of medicines. We viewed three weekly and one monthly medicine audit for February 2017. The most recent weekly audit had not identified any of the issues that we identified. This meant that audits were not sufficient to ensure that medicines were managed safely.

The above issues represented a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe. Comments included, "Yes, I definitely feel safe here" and "They [staff] always make sure I feel safe."

Staff we spoke with understood their responsibilities to recognise and report signs of abuse. The provider had a safeguarding policy and when abuse was suspected met their responsibilities to inform the local authority and the Care Quality Commission (CQC).

At our previous inspection in April 2016, we found that although the provider maintained a call bell system, on occasions the system was not working. At this inspection we found that the provider was carrying out regular checks of the system to ensure it was working well, which we confirmed by checking the logs of the system. These logs showed that call bells were answered promptly, usually within five minutes, and we saw

staff hurrying to answer emergency calls promptly. However, we found that staff working in some areas of the building were unable to hear the alarm, which meant that when we activated a call bell in a communal lounge nearby staff were unable to respond immediately. The provider told us that this had occurred because the volume of the alarm was reduced when the batteries were low, and that this would be detected by daily checks of the alarm panel.

The provider carried out a system of checks to monitor the safety of the building. Night checks included checks of doors, windows, wheelchairs, the cleanliness of the service and confirming stock and fridge temperature checks. Health and safety checks included monthly checks of window restrictors, including whether approved restrictors were in place and whether they withstood reasonable force. Monthly checks were also carried out on profile beds, bedrails, alarm call points and wheelchairs. Gas safety checks were in date for the kitchen and laundry. An electrical condition check had been carried out in April 2014; this had identified five potentially dangerous areas and 10 improvements which needed to be made "as soon as possible." The registered manager had followed this up in December 2016, and we saw emails which showed that these had been addressed by the provider in March 2017. This showed that the issues were addressed, however a significant delay had occurred before this was carried out. The provider had arranged for a check of water safety in June 2016; this showed that the system was free from legionella, and the provider carried out weekly flushing of unused outlets in line with their risk assessment. However, this risk assessment had identified other areas which required action, such as eliminating "dead" pipes from the water system, which had not yet taken place. The lift had been maintained by a suitable contractor, however a recommendation had been made by this contractor that a two way radio be installed in the event of a person becoming trapped. This had not been carried out, although there was an alarm bell in place should a person need to call for help. Portable Appliance Testing (PAT) had been carried out in February 2016 and was one month overdue at the time of our inspection, we saw that maintenance staff were qualified to carry this out.

The building had a satisfactory check from the London Fire Brigade in April 2017. The provider had also commissioned a fire risk assessment. This stated that the service needed to have trained fire marshals, which the provider told us they were in the process of arranging. The provider carried out monthly checks of emergency lighting, door closures and fire extinguishers. There were personal evacuation and egress plans (PEEPs) in place for everyone who used the service, which included assessing people's ability to respond to the fire alarm, their ability to evacuate, how many staff were required to support them to evacuate and what equipment was required. These were reviewed monthly, with a summary of this displayed in the main office.

A food safety check had been carried out in June 2016 and the kitchen had received the highest possible rating. Inspectors had required the service to replace worn chopping boards and to repair the fridge as temperatures were too high. We saw that this had taken place, and that fridge and freezer temperatures were checked daily, with clear guidelines for staff on acceptable temperature ranges. Food was safely stored in line with good practice, and containers were clearly labelled with expiry dates. The provider had a contract with a suitable pest control organisation, and we saw records which showed this contractor visited every month, and that the provider called them out for additional visits in the event that mice were seen or suspected. The contractor was satisfied with measures the provider had taken to manage the risk of mice, and had carried out a risk assessment before putting down poisons.

The provider had assessed risks to people who used the service, including information about how these risks were managed. These were detailed and included information on areas such as falls, mobility and manual handling needs. We saw that these were reviewed regularly. One moving and handling assessment had not been reviewed since February 2016, although the person's needs did not appear to have changed. Where people had fallen, the provider carried out a 72-hour monitoring procedure, which was used to check

on people to ensure that they were awake and alert, and to look for signs that they may be unwell such as vomiting or reporting pain. Where incidents and accidents had occurred, these were recorded with details such as when the person was last checked on, what had taken place, any injuries the person had sustained and any actions which were taken.

We saw that staff were always present in each unit, and people who used the service told us there were enough staff. One person said "There are enough staff, and they always check on me at night."
However, most staff we spoke with told us there were not enough staff to fully meet people's needs. One staff member said "We need more staff so we can spend more time with the residents." The service was operating at four-fifths capacity at the time of our inspection. Staffing rotas showed that there was at least one staff member allocated to each unit, with a senior providing support to staff on each floor. There were five waking night staff on duty each night. Staff responded promptly to call bells in people's rooms, and staff were able to use handsets to call for assistance.
We observed that people usually gathered in communal lounges on each floor, which the provider told us was to encourage companionship, and we observed staff were visible in these areas, but at certain times of the day other parts of the units were unattended. There were not always staff available to support people to go out when they chose, but the provider told us that people were supported to go out by other staff such as the activities co-ordinator and manager depending on their availability.

The provider had measures in place to ensure staff were suitable for their roles. Staff files showed that prior to being appointed, the provider had obtained satisfactory proof of people's identities and their right to work in the UK, and had obtained two references from previous employers. The provider had also carried out checks on staff with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. We were shown an index of recent checks carried out with the DBS, and where this had shown traces, staff were not working in the service.

At present, no people who used the service were able to administer their own medicines, but there were procedures in place and lockable cabinets should people be able to do so. The provider told us that the GP visited the service only when requested to do so, and that medicines reviews were requested by home staff. One person needed regular blood tests to prevent toxicity of their medicines and we saw that this was taking place, and that staff had access to contact details for their clinic for advice. The provider did not maintain a checklist for who needed a review or when these had last taken place.

There were protocols in place for medicines which were prescribed "as required", which meant that staff knew when and how often the medicine should be given, but the use of these protocols was not consistent throughout the service. Some people had charts in place to record where creams should be applied, but this was not always consistent. Controlled drugs were securely stored, but the record book was full and the index was not updated to allow ease of checking.

The service had medicines policies and procedures in place. Training in medicines was up to date and the provider carried out regular competency assessments for all care workers who gave medicines.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in April 2016 we found that the provider was not meeting regulations with regards to support of staff. This was because a significant number of staff had not received training in key areas. At our focussed inspection in December 2016, we found that the provider had made progress towards improving this, but was still not meeting this regulation.

At this inspection we found some improvements in the area of training; the majority of staff had received mandatory training, however there were still some staff who had training outstanding. For example, there were five staff who had not had training in fire safety or infection control, eight staff had not had food hygiene training and five staff had not yet received dementia awareness training, which the provider told us was now mandatory for all care workers. The provider's policy stated that some training was to be repeated either annually or biannually. However, a small number of staff were overdue for these. For example, five staff were overdue for moving and handling, one was overdue for fire safety, four for safeguarding adults training, two for infection control, six for mental capacity and four staff were overdue for training in control of substances hazardous to health (COSHH).

Staff we spoke with told us that they received enough training and that their needs were met. The provider's policy required staff to have annual training in moving and handling, fire safety, safeguarding adults and medicines, and biannual training in infection control, mental capacity, COSHH, health and safety, food hygiene and first aid awareness. However, this policy applied across all of the provider's services, and they had not assessed the needs of staff working in this service, so it was not clear if certain optional courses were actually required by staff. For example, 11 staff had not had training in behaviours that may challenge, which was listed as a non-mandatory training course, and there was no record of staff receiving training in end of life care, continence management or pressure area care, although the service provided care to people with needs in these areas.

The provider's policy stated that care workers should receive supervision every two months. We saw that this was taking place up until October 2016, but that 16 staff were not supervised in December 2016. Out of the senior care workers, three had not had supervision since December 2016. Out of the care workers, six staff had not had a supervision since October 2016, and one had not had one since September 2016, despite having recently returned to the service after an absence of several years. The provider told us they had an action plan in place to address this, and that the target was to carry out 20 supervisions by the week after our inspection. Comments from staff included "I have all the training, but the one to ones are a waste of time" and "Every month the senior supervises us, if we can't make it we are given another date."

This represented a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not always obtaining consent for people's care in line with the Mental Capacity Act (2005) (MCA). The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own

decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw that before people moved to the service, a pre-assessment form included information about whether people had capacity to make decisions for themselves and whether another person had the legal power to consent on their behalf. We saw that the provider had assessed some people's capacity to make decisions about their care, although these were not regularly reviewed. However, in four people's plans, relatives had signed on behalf of the person without any explanation as to whether they had the legal power to do so, in one case this had been signed by a staff member on the person's behalf and in another case there was no evidence of consent at all.

This represented a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). We saw that when people's liberty had been restricted in their best interests, the provider had assessed their capacity and applied to the local authority to do so. Correspondence between the provider and the local authority showed that the local authority was unable to complete these applications in a timely manner, but the provider had updated them on a monthly basis to monitor progress in carrying out these assessments and had highlighted the most urgent cases. People's liberty was restricted by placing keypads on the doors to leave each unit and to leave the front door of the service. The provider told us that they gave the code to people who were able to leave the unit safely, and people we spoke with confirmed that they were given these codes and were able to leave without restriction. This meant that the provider acted lawfully in restricting people's liberty whilst ensuring that other people's freedom was protected.

The provider did not always monitor people's weights and nutritional intake appropriately. For example, one person had been in the service for a month, and although they had been weighed once, the provider had not used this to obtain a body mass index (BMI) score or carried out a malnutrition universal screening tool (MUST) assessment to see if the person was at risk. One person's file showed that MUST scores had been reviewed yearly, but this had stopped a year ago. One person's file showed that although they were weighed monthly, staff had not assessed whether their BMI had changed or whether the weight loss was significant enough to impact on their MUST score.

The provider had completed monthly audits of people's weights, but this had not taken place in January, February or March, even though these weights had been taken. There was no system in operation for comparing changes to people's weights. This meant that staff did not always notice changes in weight. For example, one person's nutritional care plan had been reviewed in November 2016, but since this time they had lost over 6kg, which had not been noted by staff. The provider showed us a new tool that they planned to implement which highlighted changes in weight. In another case we saw that a person was seen by a dietitian who had made a series of recommendations, which were not fully implemented. The dietitian had asked that the person be weighed weekly, which was not taking place, and there was no evidence of other steps such as snacks or fortifying food taking place. The person was to have two shakes per day, which was only occasionally recorded on fluid charts. Fluid charts for this person had only been completed on two days in March and there was only a food intake chart available for one day. This meant that people were not adequately protected from the risks of malnutrition.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People we spoke with were positive about the food and the support they received at mealtimes. Comments included, "The food is good here, we have a good chef" and "They encourage you to eat your food and if you need help they help you." A staff member told us "We know what people like to eat and their food choices". We observed lunch on three of the units. Food was served promptly, was warm and attractively presented. People were given generous helpings of food with drinks and were offered choice and second helpings. People were supported to eat at their own pace by sufficient numbers of staff, and staff ensured a pleasant and relaxed atmosphere at mealtimes, for example by playing music that people liked and offering kind words and encouragement. One person said "There's usually music, it's a digestive." Dining areas were clean and well presented, with table cloths and condiments provided along with plentiful supplies of juice and water.

We observed some good practice at mealtimes, for example one staff member told a person who was eating their main meal, "I'm going to put your dessert in the kitchen for you so it's not too much" and when a person asked for just custard staff provided this.

The provider was not always following best practice with regards to the environment for people with dementia. Communal areas of these units did not make use of contrasting walls and flooring or waypoints which could aid navigation, or use personal items or symbols to support people to recognise their own rooms and communal areas. Some people we spoke with on these units were disorientated. The provider acknowledged this as an area for development. We noted that there were clothes hung up in the communal bathrooms on the first and second floors, which staff told us was where they stored people's clothes before taking them to the rooms, but the provider told us this should not be taking place. We recommend the provider take advice from a reputable source on designing a dementia-friendly environment.

A care worker told us, "The seniors update the care plans, writing when they attend GP appointments, they involve us with this so we can give them updates on the residents." We saw that records were maintained of visits from health professionals, including GPs, physiotherapists and nurses. There was a list of health professionals in people's care records, along with a serious medical condition sheet which showed the provider had discussed these with people and their relatives. Records also showed when people had accessed services such as opticians, dentists and specialist clinics.

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the caring approach of the staff team. Comments from people who used the service included, "The staff here are wonderful" and "I can do nothing for myself and the staff are really caring." One relative told us that their family member had been helped to settle in "in a very kind manner" and another said, "[my family member] could not wait to get back to the staff and other residents, this is a big change from when she first arrived and indicates how happy she is." One relative commented positively about the welcome they had received from staff when they had arrived unannounced to take a look at the service. Nobody we spoke with complained of inappropriate behaviour from staff or ill treatment.

The provider maintained information on people's wishes and preferences. For example, there was a residents' choice form kept in people's files. This was done in conjunction with people's families, and included information about people's favourite foods, favourite hot and cold drinks, their day and night routines, preferred footwear and how people preferred to wear their hair, including if they preferred their hair long or short, and for men, whether they preferred to be clean shaven. This also included information on people's pastimes, preferred music and newspapers and which animals they liked. This meant that people were involved in decisions about their care. A care worker told us, "We offer people choices for personal care, we give them three outfits to choose from and ask them what they would like to wear, and if they don't like the outfit they will request another one."

People who used the service told us they had a regular meeting with managers. Minutes showed that these were taking place monthly, and were used to consult on activities and seek suggestions, and people were asked if they felt the service treated them with dignity and respect. Managers also held quarterly meetings with relatives, and these were used to discuss and consult on changes to the service, including introducing more senior staff members and making changes to dining arrangements in areas of the service. We saw that information on advocacy was displayed on noticeboards, and the provider told us that one person at present was involved with an advocate as they were seeking to move out.

We saw that when people appeared distressed, staff were patient and empathetic. In one case, a person was reassured by staff who said, "You're not being a nuisance, not at all." We saw that people were greeted by name by staff when they entered the dining room. Staff also gave thought to the environment, for example when a television was turned up too loud for people to hear others, we saw staff turned this off and put on music instead. Music was played thoughtfully, with volume levels kept at an appropriate level, and we saw staff asking people what music they wanted. Staff used this as a starting point for conversations with people, and sang along with people to music they knew. People told us they enjoyed listening to music; one person told us "You have the music to soothe you, staff are very kind".

We observed respectful interactions between staff and people who used the service. People were referred to by their chosen names and we saw that the staff knocked and called people's names before entering their rooms. There was a reference guide on the noticeboard for people and staff on how people should be treated with dignity, with reference to people's attitudes, behaviours, compassion and dialogue. Care plans

also included information about how to maintain people's privacy, including whether people preferred to be cared for by male or female staff, however in some cases this information was not correctly recorded, for example by ticking the box marked "yes" even when these contradicted one another.

The provider told us that at the time of our inspection, nobody was receiving end of life care. We saw that people's end of life needs and wishes had been considered. For example, people's religious needs were considered, with people stating whether they wished for prayers to be said, a minister of religion to be contacted, or whether they did not want religious involvement at all. One person's plan stated that they did not wish to be resuscitated, and another stated their wishes for what would happen to their body after death. Where a person's end of life care plan was blank, staff had recorded that this was because the person did not want to discuss this.

We also saw that the provider recorded details with people and their families about notifying people's families in the event of the person becoming unwell or suffering an injury, and when and whether relatives wished to be informed if the person was dying or had died. This included when the families wished to be informed, for example immediately, the next morning or at the time of their next visit.

Good

Is the service responsive?

Our findings

Relatives we spoke with told us that care plans were regularly reviewed and that staff made a strong effort to understand the preferences of individuals. They also told us that staff were good at helping new arrivals to settle in by giving them lots of individual attention. A care worker told us, "Before people are referred into the service they inform us about [their needs] we make sure their rooms are arranged, we give them support with choices, everything is good here." Another care worker told us "Every resident has their own way, different needs. I like to listen to their needs."

Prior to joining the service, an assessment of people's needs had been undertaken, which included areas such as mental health needs, oral health and hygiene and continence needs. There was information on people's personal details, diagnoses, and the involvement of families and other professionals, and this information was used to inform care plans.

Care plans included medical history, medicines and personal care needs, and people's needs around dressing, continence, eating and drinking, communication, oral health, foot and nail care, mobility, awareness and orientation, moods and anxiety, pain and discomfort, sleep patterns and cultural needs. There was information on whether people suffered pain and discomfort, how people's independence and privacy were maintained and information relating to personal safety and risk and people's desired outcomes. These were comprehensive in the information they held and were clearly referenced. Where appropriate these plans had been reviewed monthly. Plans included personalised information such as whether people wanted to participate in group activities. Staff maintained an hourly record which indicated people were supported in line with these plans. A care worker told us "I ask if they would like a shave or a wash, and if they would like their hair brushed. If they refuse personal care I write this in the notes and report it to the manager."

People who used the service benefitted from an interesting and varied activity programme, which was run by a dedicated activities co-ordinator who was based at the service three days a week. There were scheduled activity sessions carried out twice a day. Activities included ballgames and quiz sessions, makeovers, singing classes, arts and crafts, tai chi, cooking, tea parties and bingo. The service hosted a movie night on Saturdays. There was a dedicated allotment in the shared garden which people used to carry out gardening activities. In addition the provider arranged activities marking a wide range of occasions, examples of these included St Patrick's Day, Parkinson's Disease Day, the Queen's birthday and National Garden Week. People told us that their birthdays and other special occasions were celebrated.

The activities co-ordinator had a strong and enthusiastic presence in the service, and told us "I absolutely love my job, I engage people with many things to do, I like to keep them active. I just like seeing them smile at the end of the day."

There was clear information displayed in the building about how people could make a complaint. People we spoke with told us that they felt confident they could raise concerns and that they would be listened to. Comments included "I am very confident that I can complain if necessary" and "Oh yes, they do listen."

Where people had made complaints about the service, these were recorded by the registered manager and acknowledged. Complaints were investigated by managers and responded to appropriately, and where a complaint was upheld the service had apologised and where necessary addressed this with the staff responsible.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider did not store confidential material appropriately. For example, we found that the main desk in reception was frequently left unattended. Confidential information was left out, including information on medicines, a list of people who required incontinence pads and a person's entire care file. Care workers had also logged into the computer at this desk but had left the screen unlocked, which meant staff emails and electronic folders would be accessible. We also noted that daily records were left on top of kitchen cupboards which were left accessible and unlocked. These issues had been noted in an external audit and discussed in a meeting of senior staff in February, but had not yet been addressed. Additionally, in the complaints folder, we saw that one relative had complained that the service had sent confidential information to an incorrect address.

There was a system of weekly audits carried out by the registered manager, which included assessing accidents, pressure ulcers and wound care, care plans, medicines, housekeeping, kitchen and dining experience and activities and maintenance. However, in practice these were not taking place weekly, and the most recent weekly audit had taken place on 10 February, which was seven weeks prior to the inspection. Similarly, the monthly weight audit had not been carried out for three months. We found that records of supervision were not filed or well organised, and so managers were not always aware of when people's last supervisions had taken place. In some instances forms were not checked to ensure that they were correctly completed, for example when staff had ticked "yes" in response to all questions about a person's wishes, even though these were contradictory.

We also found that records were frequently not checked by senior staff. For example, records of temperatures of fridges, freezers and hot water used for personal care were maintained by staff, but were not signed off by senior staff. We found that records of nutritional intake and turning charts were also not signed off, which meant that when these records were either incomplete or contained issues of concern no action was taken.

The above issues constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they were happy with the management, with one person telling us, "This home is generally well run, I have no complaints." However, some relatives had complained to the service about a lack of communication. One relative approached the registered manager during our inspection to say that they were concerned that there was a deterioration in their relative's condition but that they were not getting feedback from staff. The provider told us that the Head of Care post was not covered whilst the staff member was on maternity leave, and that the Deputy Manager post was uncovered for a number of months whilst a new staff member was recruited.

Comments from staff included "The registered manager is good, she tried to do her best" and "I feel like I am not listened to, we do get surveys which I fill out and send, but they don't listen so why bother."

A number of staff told us that they were not listened to at staff meetings and that managers did not listen to their views or take suggestions on board. We found that team meetings were taking place regularly, however attendance at care worker meetings was not sufficient to ensure that information was well communicated. For example, three staff attended the February team meeting, only one attended the January meeting and five attended in December, for which there were no minutes available. Meetings were used to discuss health and safety issues, training needs and areas for development, discussing with staff the need to put people who used the service first, and discussing policies and procedures for use of mobile phones and calling in sick. The December team meeting was used to address the fact that at our last inspection water temperatures were not being taken prior to carrying out personal care.

Meetings were carried out regularly amongst the senior care workers, these were well attended and used to discuss areas for development, such as medicines stock checks, water temperatures, supervisions and appraisals. Seniors discussed the needs of people who were joining the service and carried out a daily handover. This included discussing people's current condition, medicines issues and upcoming appointments and visits. This was also used to review incidents and accidents, and how many people were on fluid balance charts.

The provider carried out a system of external audits. An area manager conducted a six monthly visit, which involved checking that actions from the last compliance visit had been carried out, and carried out a comprehensive series of checks including premises, nutrition, care plans, management of medicines, staff training and observations of care delivery. These were effective at identifying issues such as incomplete nutritional charts, incomplete audits, checks of water temperatures and gaps in staff training and supervision. Some of these issues had been addressed by the registered manager, and in some areas there was a development plan in place for the service to address these. However, some identified areas such as nutritional charts and confidential information had not been addressed at the time of our inspection. The area manager showed us a new compliance management tool that had piloted in other services. This required managers to carry out a monthly audit and provide data in a large number of areas such as incidents and accidents, safeguarding, staff and residents meetings, infection control, medical needs, emergency calls, weight monitoring (including people who had experienced significant weight loss) and information on people's pressure care needs. The provider told us they would be implementing this in the service from April.

Where complaints or allegations had been made against staff, we saw evidence that appropriate investigations and disciplinary actions had taken place. The provider was appropriately displaying their certificates of registration and their current rating from the Care Quality Commission (CQC). Where significant incidents or events had taken place, the provider was meeting their responsibilities to inform CQC.

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 11 HSCA RA Regulations 2014 Need for consent Care was not provided with the consent of the relevant person. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure receipt by a service user of suitable and nutritious food and hydration which was adequate to sustain life and good health 14(4)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user or assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity17(2)(a)(c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was reasonably practicable to mitigate risks to people who used the service, ensure that the premises were safe for their intended purpose or ensure the proper and safe management of medicines 12(2) (b)(d)(g)

The enforcement action we took:

A warning notice was issued