ARMSCARE Limited

Summerville House

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

This comprehensive inspection took place on 14 January 2019 and was unannounced.

Summerville House is a 'care home'. 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.

Summerville House is registered to accommodate up to 26 people. Care is provided over two floors. There are communal areas that people can reside in along with space for dining on the ground floor. At the time of our inspection visit 22 people were living in the home, all of whom were living with dementia.

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

At the last inspection of Summerville House, we rated the home overall as good. At this inspection the overall rating has reduced to requires improvement. We also found the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all risks to people's safety had been assessed and therefore mitigated. Staff practice was mixed which placed people at risk of avoidable harm. The provider had determined the number of staff required to meet people's needs but this had not regularly been met. Staff told us they struggled to provide people with stimulation to enhance their wellbeing.

Staff working on the night shift had not all received training in how to give people their medicines safely. This meant there may have been a delay in people receiving medicines for pain or distress. Following the inspection visit, the registered manager told us this had been corrected.

Some staff were observed to lack the necessary skills when dealing with people living with dementia. Most had only received training in this area online via a computer. The provider told us training for staff in this area was being improved to give them better knowledge and skills.

Most people were treated with dignity and respect although this was not consistently applied by staff and some people did not always have choice or control over their care. People's consent had not always been sought in line with the relevant legislation.

People did not always have a choice of food to eat and the dining experience required improvement. People who were at risk of not eating enough were monitored to ensure they had sufficient food to remain healthy. We were not made aware of any concerns regarding people's fluid intake however, the systems in place to

monitor if people had received enough to drink were not robust and needed improving.

The current governance systems and processes in place were not all effective at monitoring the quality of care people received or to drive improvement within the home.

The premises would benefit from some improvements to help people living with dementia orientate themselves. We therefore recommend the provider consults appropriate guidance in this area to make the necessary improvements.

People received their medicines when they needed them and systems were in place to protect them from the risk of abuse. Any incidents or accidents that had occurred had been fully investigated and lessons learnt to try to prevent them from happening again.

When people became unwell, the staff acted quickly to ensure they received the appropriate medical advice. Staff were very happy working at the service. They felt supported, told us their morale was good and could develop and complete qualifications within care.

There was an open culture in the home. People and relatives could approach the staff or manager whenever they wished and were listened to and their opinions respected.

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.

Not all risks to people's safety had been assessed or managed well to protect people from the risk of avoidable harm.

The provider had not ensured that the number of staff they required to work on each shift had been consistently met.

Most of the home and equipment that people used was clean but not all staff used good practice to protect people from the risk of infection.

Systems were in place to protect people from the risk of abuse.

People received their medicines when they needed them.

Incidents and accidents that had occurred had been fully investigated and lessons learned.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent had not been sought in line with the relevant legislation

The delivery of staff training required improving to ensure their skills and knowledge was sufficient to enable them to provide people with effective care.

The premises were in good order but would benefit from further adaptation to meet the needs of the people living there.

People received enough to eat to meet their needs but the lunchtime experience could be improved as could the monitoring of what people drank where this was a concern.

People had access to appropriate services to help them maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and caring but they did not always treat people with respect.

People were not always encouraged to express their views or given choice about their daily care.

Staff encouraged people's independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care had been planned and was delivered to meet people's physical needs but there was a lack of stimulation to enhance their wellbeing.

People knew how to raise a concern and were confident they would be listened to. Systems were in place to investigate into complaints and learn from them.

People received support at the end of their life to ensure it was dignified and pain free.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The current governance systems in place had not been effective at mitigating some risks to people's safety.

CQC had not always been notified of certain incidents that had occurred as is required.

There was an open culture in the home and staff were happy working in the service.

People and relatives were involved in improving the quality of care they received.

Summerville 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.

This inspection took place on 14 January 2019 and was unannounced. It was brought forward due to concerns shared with us by the Local Authority about the quality of care being provided within the home. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed the information we held about the service. This included important events the service must tell us about by law, previous inspection reports and any information we received from the public about the service.

Most people living in the home were unable to provide us with feedback about the care they received however, we did speak to one person about this subject. We also spoke to four visiting relatives of people receiving care and spent time observing how staff engaged with people to promote their safety and wellbeing. Five staff were spoken with along with the registered manager, the provider's regional manager and the managing director of the provider.

The records we viewed included four people's care records, people's medicine records, two staff recruitment records, staff training records and other information in relation to how the provider and registered manager monitored the quality of care people received.

Requires Improvement

Is the service safe?

Our findings

Following our last inspection of this area in February 2017 we rated safe as good. At this inspection the rating has reduced to requires improvement.

Risks to people's safety had not always been assessed or managed appropriately placing them at risk of avoidable harm. In some people's rooms we found razors and prescribed creams that were not being kept secure. There were also stairs from the ground to first floor that were accessible to people. The registered manager told us there were people living in the home who were independently mobile and may not understand what the razors or creams were or any risks associated with using the stairs. However, they had not assessed whether these areas were a risk to people's safety.

One person required their drinks to be thickened to reduce the risk of them choking. They had recently been assessed by a speech and language therapist as requiring two scoops of thickener in 200mls of liquid. However, the staff member who thickened their drink at lunchtime told us they had only added 1.5 scoops of thickener. Another staff member said they only added 1 scoop of thickener. The person's risk assessment stated that one scoop was required for every 150ml of liquid. Not adding the correct amount of thickener to the person's drinks and having incorrect information within their care record placed the person at risk of harm.

We observed some staff using poor practice when supporting people to move. For example, from a chair to a standing position. They used an underarm technique which could place people at risk of injury.

The staff rotas also showed that there was not always a staff member working at night who had been trained to give people their medicines. The registered manager told us that they and another staff member could be called into the home to do this as they only lived a short distance away. They said it would take five to 10 minutes to reach the home. However, this meant that people may have to wait for pain medicines or medicines to help alleviate their distress which is not appropriate.

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

The provider told us they would take immediate action in relation to these areas to protect people's safety. The registered manager confirmed shortly after the inspection they had reminded staff of the correct amount of thickener the person required and updated the care records to reflect this. They also said that all night staff had received training on how to give people their medicines safely.

There were not always sufficient numbers of suitably qualified, competent, skilled or experienced staff deployed to meet people's needs. The staff we spoke with said that when they were fully staffed they could keep people safe and meet their physical needs. However, they all said they felt they did not get much time to engage with people and that sometimes the only interaction they had was when completing a task. Two staff said this was particularly difficult in the afternoons when four staff were on shift as they had other tasks to complete. These included giving out drinks, serving the evening meal and laundry tasks. One of the

relatives we spoke with agreed with this. They told us, "In the afternoon the carer's time is taken up heating soup and providing sandwiches. It would be better spent caring for the residents."

We spoke with the registered manager about this. They told us that staffing levels were calculated based on people's needs. They said they had recognised some months ago the need for an extra staff member from 4pm to 6pm each day to help at tea time. However, this they said had been difficult to recruit to and therefore currently, this shift was only periodically being filled. We checked the staff rotas for the two weeks before our inspection and found that on only two out of 14 days this shift had been filled.

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

Everyone we spoke with said they felt they or their family member was safe living in the home. A relative told us, "She's very safe here. They use a pressure mat so they know when she's on the move so they can intervene. As she can be a bit restless, they moved her downstairs to a room near the front door because they're always passing through that area."

The staff we spoke with understood what abuse was and were clear they would report any concerns to the registered manager or the provider. However, they did not all know who they could report their concerns to outside of the home if they needed to do this. Any safeguarding concerns had been reported to the local authority as is required but CQC had also not always been notified of such events. Where a safeguarding concern had been raised, the registered manager had fully investigated these and put measures in place to protect people where needed although records of this investigation were not always available. Improvements were therefore required in this area.

Risks associated with people developing pressure ulcers or of having falls had in the main been managed well and staff ensured for most of the inspection the appropriate equipment was being used to reduce this risk. One relative told us how their family member had experienced several falls in the past but that this had been responded to and therefore, they had greatly reduced. However, on one occasion we observed a person did not have their frame near them when left alone in the dining room for a period of 30 minutes. The registered manager noticed this during their walk around of the home and moved the frame within the person's reach which staff had neglected to do.

One person whose care we looked at had bed rails on their bed. The registered manager told us this was to protect them from the risk of falling from bed at night. They said the person was safe using the bed rails but no risk assessment in relation to this had been completed to evidence what checks they had made. Again, as at the last inspection, there was no guidance in place for staff regarding the size of the gaps between the bed rails and the bed to help staff judge whether the bed rails were safe. The registered manager said the rails were checked but could not tell us about the recommended gap size and no records of these checks had been kept. Improvements are therefore required in this area.

In respect of fire safety, we observed that fire exits were clear and staff could demonstrate they would know what action to take in the event of a fire. Risks in relation to legionella bacteria, burns from hot surfaces or water and lifting equipment had been managed well.

Improvements were required to the provider's recruitment processes. Most checks to ensure prospective staff were of good character had been completed. For example, references from previous employers had been sought and a Disclosure and Barring Service check had been completed to see if the staff member was barred from working within care or had a criminal record. However, a full employment history had not been

gathered or a written explanation for any gaps documented as is required.

The home and equipment that people used was clean. On most occasions we saw staff using good practice to prevent the risk of the spread of infection. This included washing their hands and/or using gloves and aprons when appropriate. We did however observe one staff member wiping some urine from the floor with a cloth without wearing the appropriate protective equipment. They also did not clean the floor thoroughly. This was poor practice.

The relatives we spoke with told us their family members got their medicines on time. People's oral medicines were stored securely for the benefit of people living in the home and medicine records indicated people had received their medicines when required. Good systems were in place to ensure people's medicines did not run out. Information was in place in line with best practice to guide staff on how to give people their medicines safely. This included for PRN medicines that were prescribed on an 'as and when basis'.

Staff demonstrated they were aware that any incidents or accidents that occurred had to be documented and reported. Lessons had been learnt from these and actions taken where appropriate to reduce them from re-occurring. For example, one person had experienced a fall and therefore a sensor mat had been put by their bed at night. This ensured that staff were alerted if the person was getting out of bed so they could provide them with any assistance they required whilst trying to prevent them from having fall.

Requires Improvement

Is the service effective?

Our findings

Following our last inspection of this area in February 2017, we rated effective as good. At this inspection the rating has reduced to requires improvement.

Consent had not always been sought in line with the relevant legislation. The registered manager told us that most people living in the home lacked capacity to make some decisions for themselves. Therefore, staff had to work within the principles of the Mental Capacity Act 2005 (MCA) when supporting these people. The 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The staff we spoke with understood the importance of helping people to make their own choices regarding the care and support they received. However, they were not all clear that where people could not consent, any actions they needed to take had to be in people's best interests. Staff practice was also variable in this area. Some staff always asked people for their consent before performing a task, offered people choice such as where to sit or what they wanted to drink and supported people to make decisions. Other staff did not do this. For example, some staff were seen placing or removing clothes protectors from people without asking them first. On other occasions, staff moved people in a wheelchair without asking if this was okay or explaining where they were moving them too.

Prior to the inspection we noted the provider had several photographs of people on their public internet page. The registered manager told us that some of these people had not been able to consent to this so relatives had done this on their behalf. However, these relatives did not have the legal authority to give this consent and the principles of the MCA had not been followed when making this decision. We found other relatives had consented to aspects of people's care where they did not hold the relevant legal authority. There was also a lack of mental capacity assessments and best interest decisions in place for certain decisions such as the use of bed rails or sensor mats that could restrict people's movements.

This was 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The manager told us that applications had been made to the Local Authority where they felt they were depriving people of their liberty. They were waiting for these to be assessed. In the meantime, they told us they utilised the least restrictive practice and kept these people's needs under regular review.

The relatives we spoke with gave us mixed views about the skills and knowledge of staff. One relative told us, "They are very good. Some of the younger ones need more experience but they're willing and most of them are first class." One person said, "I think they know what they're doing, they're so helpful and kind." However, another relative told us, "I'm not sure the training methods they use are the best. They seem to rely on computer training and in my opinion, for this sort of work, having someone there in front of you showing you what to do is far better."

The staff we spoke with said they felt the training they had received was adequate although two said they would prefer face to face training rather than online training. They also told us that their competency to provide people with safe and effective care had been assessed. However, we were concerned that not all the training and the supervision staff had received was effective. This was because we observed some staff using poor practice during the inspection. Records showed that some staff supervision was behind and had not been completed in line with the provider's requirements.

We therefore spoke with the registered manager about staff training and supervision. They confirmed that most staff training was delivered online and that this included dementia training. The regional manager told us they were aware that staff practice in this area needed to be improved. They said plans were in place for staff to have further training in dementia in a classroom basis rather than via a computer and that this was being explored for other subjects. For example, staff had recently received training from a dentist in oral healthcare. They said plans were in place to bring staff supervision up to date and we saw that the completion of supervision had recently improved.

We observed the lunchtime meal in the dining room and found that this experience could be improved for people. People were offered a choice of drink but not a choice of food. One person had a large amount of gravy poured on their meal without being asked if that was what they wanted. The chef told us that people could ask for alternatives but we did not see this occur, even by those people who did not eat their meals. One person who had not eaten all their main meal and we saw a staff member offering people more potato croquettes. We heard them say, "Oh, I like those, can I have more?" However, the staff member told them 'no' and moved off to another table.

There was a menu displayed on a wall that had pictures of food but these did not match the meal that was on offer and not all people could see the menu. There was a lack of condiments for people to access themselves and some staff did not interact with people when assisting them to eat. We were also concerned about the spacing of meals. One person had been observed eating their breakfast at 10.30am but where then served their lunchtime meal at 12pm. This was unlikely to have been a sufficient gap between their meals.

There were several people who required assistance or prompting to eat their meals. Most received sufficient support however one person did not. They received their main meal at 12pm but made no attempt to eat it. Their first prompt to eat was at 12.26pm when it was likely the meal was no longer hot. A few minutes later staff took away the main meal and replaced it with a dessert. Staff pointed out the dessert to the person on eight occasions but none took the time to sit with the person to try to encourage them to eat. Their dessert was eventually removed untouched. The person was not underweight but their care record stated they did sometimes need help and encouragement from staff to eat and drink, particularly on a 'bad day' but staff had not done this effectively which was poor practice.

The relatives we spoke with told us they were happy their family member received enough to eat and drink. People's eating and drinking needs had been assessed and where staff were concerned people did not receive enough eat, their intake was being monitored. Drinks were brought around on a trolley regularly

throughout the day but otherwise, people could not freely access drinks which they may benefit from and would allow them to drink as and when they required.

Staff were recording people's fluid intake where they were concerned they were not drinking enough and two people's records we checked showed they were drinking adequate amounts. However, on the day of the inspection visit staff were not always clear what people had drank. One staff member told us they were responsible for recording people's fluid intake but as they were helping people get up they had not been able to monitor what people had drank. Therefore, they said they had to ask other staff later in the day what people had consumed. We overheard staff saying they did not know and therefore, people's fluids were not being monitored effectively.

Staff were knowledgeable about people's individual dietary requirements as was the chef and these were catered for. For example, where people required a soft diet to meet their needs. Advice had been sought from relevant healthcare professionals about people's dietary needs and this had been listened to and implemented in most cases.

Most of the premises was in good decorative order although there was a broken skirting board in the conservatory that required repair. There was a secure and pleasant garden that people could access freely when they wished to. There was good signage in the home that directed people to the communal areas within the home such as toilets and lounges. Pictures were on the walls for people to observe and take interest in. There were other seating areas within the home where people could choose to reside.

The lighting in most areas of the home was good however, on one corridor the lights were triggered by movement. One person was regularly sitting in this area trying to look through a book. As there was no movement in the corridor the lights regularly went out placing them in darkness. This also meant this corridor was gloomy and difficult to see for people when they started walking through it and may not be appropriate for people living with dementia. There was also a lack of hand rails for people to use when walking in the corridors.

Although people had their names on the door of their rooms, there were no other distinguishing features to help people orientate themselves to their room such as memory boxes. We therefore recommend the provider consults best practice regarding the environment for people living with dementia and make the necessary improvements.

People's needs and most of their individual preferences had been assessed without discrimination. Technology was being used when providing people with care. This included the recent introduction of a new care planning system where staff used hand held devices to record what care and support people had received and equipment such as sensor mats. However, not all care was being delivered in line with the relevant legislation or best practice.

All the staff said they worked well as team. They were knowledgeable about people's healthcare needs and told us about the healthcare professionals they worked with to meet these needs. Relatives told us their family member they could see the doctor or that medical assistance was received when they required this. One relative told us, "If [family member] needs to see a doctor or nurse, they will arrange that. It has happened a few times and there's no problem." Another relative said, "There's no problem getting to see a doctor, or optician. [Registered manager] will organise it if that's what's needed." Records showed that people's health care needs had been assessed. On the day of the inspection visit, staff reported some concerns about a person's health to the relevant healthcare professional for advice and guidance.

Requires Improvement

Is the service caring?

Our findings

Following our last inspection of this area in February 2017, we rated caring as good. At this inspection the rating has reduced to requires improvement.

The person and relatives we spoke with told us that staff were kind and caring and treated them or their family member with dignity and respect. One person told us, "They're lovely, they're kind to me. I like it here."

The staff we spoke with knew the people they supported well. They spoke about them in a caring and respectful way and understood their life history. We observed mixed practice from staff when they interacted with people. Some did this in a very kind, caring and compassionate way. They sat with people, talking to them quietly whilst holding their hands. Other staff always explained to people what they were doing, for example when they were supporting a person to move in a hoist. This had the effect of calming the person. However, other staff did not always treat people with respect.

One staff member whilst supporting a person to eat, rushed them by loading their fork with food before the person had finished their mouthful. The staff member also did not interact with the person. Another staff member did not provide any explanation to a person when they moved them in a wheelchair. One person was observed constantly walking around the home but some staff were hesitant to engage with this person when they walked past them, even when the person was asking questions.

Relatives told us they felt involved in the planning of care for their family member and could be involved in making decisions where necessary. Staff were variable in their practice in supporting people to express their views and involving them in making decisions about their care. People were not always given choice to make decisions such as where to reside in the home or what to eat or drink. We also observed one person getting up from their chair wanting to walk out of the lounge. Rather than assisting the person to walk to where they wanted, staff guided them to sit back down in their chair again.

People's communication needs had been assessed and staff had a good awareness of how to support people in this area but we did not always see staff communicating with people effectively. The registered manager told us that documentation was available to people in different formats should it be required to help them understand the care that could be offered.

People's spiritual needs were met. Representatives from various faiths visited the home each month to provide people with readings and/or a church service.

People could personalise their room with their own belongings such as bedding and pictures to provide them with comfort and we saw that many people had chosen to do this. Staff told us they encouraged people to be as independent as possible for example, with personal care. We observed staff on occasions encouraging people to walk when they could or placing food on their cutlery and then encouraging them to eat themselves. People's medicines were also put into their hands so they could take it themselves.

Requires Improvement

Is the service responsive?

Our findings

Following our last inspection of this area in February 2017, we rated responsive as requires improvement. At this inspection we have continued to rate responsive as requires improvement.

At our last inspection we recommended that the provider seek advice and guidance from a reputable source about the delivery of meaningful activities for people but we found this had not improved.

The relatives we spoke with told us there were some organised events to provide people with stimulation such as singing and playing with a ball and that major events such as Christmas or the World Cup were celebrated. But they said these things did not occur very often. One relative told us, "I think it's very hard to find things to do for people with dementia. A lot of them here either sit and sleep or shout and wander around all day. I can't see there's a lot they can do for them other than look after them." One person told us how they had gone on a trip to Sandringham in the summer.

All staff said they did not have much time to interact with people or engage them in meaningful activities. They said that a staff member who worked for the provider visited the home approximately once a week where they engaged people in activities such as arts and crafts or baking. They said sometimes they could paint people's nails or throw a ball with people. There were various items such as hats, handbag, coats and books that people could utilise if they wished to and we saw one person looking at the hats. On the day of the inspection we did not see any activities offered to people. People spent most of their time either sitting in the lounge or walking around the home.

People's social interests had been assessed when they moved into the home and recorded within their care record. For one person it had been recorded that they liked talking, playing games and pets. For another person they liked to look at books or magazines and the guidance was for staff to sit with the person doing this. We did not see either person engaged in any of these activities during the inspection. Also, the records of their care for the 14 days prior to our visit did not show they had been involved in any activities of any type.

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

The relatives we spoke with were happy that other aspects of the care provided met their family member's needs. One relative told us, "[Family member] always looks clean and tidy which is important as this has always been important to her." Another relative told us how the registered manager has asked certain staff to work with a person as they could speak their native language. The relative told us, "It has made a big difference."

We observed mixed practice from staff regarding being responsive to people's needs. Staff did regularly ask people if they were okay and one noticed that a person looked uncomfortable in their chair and so helped them to re-position. Another provided a person with a tissue when they needed it. However, one person

constantly walked throughout the home into different areas and was very confused. Staff did not attempt to engage this person in any form of activity.

An assessment of people's needs had taken place before they started using the service to ensure the provider could meet these. Where they were able, people had contributed to the planning of their own care. If required, relatives had also been involved. Relatives told us that communication about their family member's needs was good and that they were involved as much as they wished to be. One relative told us, "If something happens to [family member] they call me."

The assessment of people's preferences was variable. Some preferences such as the times people liked to go to bed and whether they wanted a female or male carer had been recorded. However, people's bathing preferences had not been specifically recorded. For one person their record showed they had only had one shower in the 14 days prior to our inspection. For another person, they had not had a bath or shower at all, rather a bed bath. We spoke with staff about this. They said they offered people a bath or shower each day but that some people often refused to have either.

Records were in place to give staff guidance on how to provide care to meet people's needs. Most of these had been recently reviewed and were up to date. However, one person's record in relation to the amount of thickener they required in their drink was inaccurate and had not been updated since this changed on 4 January 2019 and had led to staff being confused regarding the correct amount to apply. Since the inspection visit this has been corrected.

On the day of our inspection visit, many relatives came to visit their family member living in the home. Relatives told us they were encouraged to visit regularly and could visit the home at any time. They added that they were always made to feel welcome. This helped to reduce social isolation and encourage feelings of wellbeing.

People and relatives told us they knew how to complain and had felt comfortable raising concerns if they needed to. One relative told us, "If I'm not happy with the care mum's getting, I say so." They went on to tell us their concern had been resolved to their satisfaction. The registered manager told us that no formal complaints had been received. A new system had recently been put in place to record any concerns that had been raised so the provider could identify any patterns and learn from them if required.

The staff had received several compliments from relatives regarding the care they had provided to their family member at the end of their life. One we saw stated, "[Family member's] time with you was so comfortable and peaceful.' Where people or relatives were happy to give this information, their wishes regarding their death had been sought and were respected. Advice and input from palliative care professionals had been received where required with appropriate support, equipment and medicines. This helped ensure they were comfortable, dignified and pain free at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

Following our last inspection of this area in February 2017, we rated well led as good. At this inspection the rating has reduced to requires improvement.

Not all the current systems and processes in place to monitor the quality of care provided and to mitigate risks to people's safety had been effective. This placed people at risk of poor care.

Neither the registered manager or the provider had considered potential risks to people's safety from razors, unsecured creams or stairs. Some staff told us there was no system in place to ensure they were kept up to date with people's changing needs if they had been absent from the home for more than one day. These staff were not aware that one person had a new prescription for their thickener which placed the person at risk of harm. People continued to lack daily stimulation and people's social needs were not always being delivered. This had not been identified as an issue by the provider.

During the inspection some staff used poor practice in areas such as moving and handling or supporting people to eat. This demonstrated a lack of monitoring and action from senior staff to ensure that staff used safe and appropriate techniques. On one occasion a staff member used poor technique when supporting someone to move but the senior member of staff did not intervene although they were present. Also, one staff member had been responsible for monitoring people's fluid intake but had been involved in completing other tasks which made it impossible for them to do this effectively. This was an example of poor leadership and allocation of tasks.

The registered manager was aware the provider's required staffing levels had not always been met. The provider told us they thought this shift had been filled and was not aware that it had not. The provider had not identified this as an issue through any audits and therefore no action had been taken to correct this such as the use of agency staff. There was a lack of awareness regarding consent and the Mental Capacity Act 2005 which had led to a shortfall in this area. None of the issues we found in this area had been identified through the provider's existing auditing.

Current audits had not identified that all the required recruitment checks had not been made before staff started working for the service. This was a concern that had been identified by the Local Authority during an audit in August 2018. The provider had also not identified that CQC had not been notified of certain events that they are required to by law.

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

CQC had not been notified of all required events. Two people had experienced unexplained bruising which the registered manager had reported to the Local Authority safeguarding team. Any events that are reported to this team should also be reported to CQC.

We received mixed views from relatives regarding the running of the home although everyone said the registered manager was approachable and caring. One relative told us, "He's a hands-on manager, he's always about the place." Another relative said, "if I have a problem about anything to do with [family member's] care or safety I'll have that conversation with [registered manager], it's not a problem for either of us." However, one relative told us, "I think [registered manager] is a caring man, I have no doubt about that. But I'm not sure he's particularly good as a manager. He lets some members of staff do things their way so there isn't a consistent level of care and I think that's partly his lack of management skills and a lack of training, both for him and the carers."

There was an open culture within the home. Relatives and staff said the registered manager was approachable and available to them at any time. Staff said they felt supported and valued and were happy working in the home.

People and relatives' opinions about the quality of care provided had been sought and relatives were satisfied any suggestions they made for improvement had been listened to. One relative told us, "I go to the relative's meetings because it's an opportunity to hear what's happening but also we have the chance to voice our opinion in a formal way which is documented and I think that's important." Another relative said they were asked for their opinion and although they could not always attend the meetings, always received a copy of the minutes so they knew what had been discussed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Not all care and treatment had been planned and delivered to meet people's individual needs and preferences. Regulation 9 (1) and (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment had not always been provided with the consent from the relevant person. Regulation 11 (1) and (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Not all risks to people's safety had been assessed or practical action taken to mitigate such risks. Regulation 12 (1), (2) (a), (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Not all systems in place to assess, monitor and improve the quality of care were effective at doing so nor were they effective at mitigating risks relating to the health, safety and welfare of service users. Regulation 17 (1), (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed to meet people's needs. Regulation 18 (1) and (2) (a).