Four Seasons (Bamford) Limited

Elm Bank Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

An unannounced inspection was carried out at Elm Bank Care Home on 23 October 2018. An announced visit took place on 24 October 2018. This was a responsive inspection as we had received information of concern about the care home from external health and social care professionals.

Elm Bank is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Elm Bank is registered for 48 places but has 42 bedrooms (some of which were previously used as shared rooms). At the time of this inspection there were 38 people accommodated, including people who were living with dementia. The home was set over three floors, each of which had separate facilities.

There was a registered manager in post. They were not present at the time of the inspection. A 'Resident Experience' support manager was managing the service so we have referred to them as acting manager throughout this report. 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.

The provider's governance systems had not always been rigorously or effectively applied. This meant several shortfalls in the standard of the service had not been identified by the quality audit processes. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - good governance.

You can see what action we told the provider to take at the back of the full version of the report.

Prior to the inspection there were concerns that potential safeguarding incidents had not been acted upon and had not always been reported to the safeguarding authority. Also, unwitnessed falls and injuries had not been reported in line with local safeguarding protocols. This meant people had not always been protected from potential risk of harm. Recently, the acting manager had made sure that accidents and incidents were acted on, reported and appropriate preventative measure were put in place to reduce the risk of further harm.

Staffing levels were based on people's assessed dependencies but the dependency assessment records were not up to date. Call bells were not always answered in a timely way so sometimes people had to wait for assistance. We have made a recommendation about this.

People said they felt safe and comfortable at the home. Risk assessments were in place about people's safety and about the premises. The home was comfortable and maintained. There were some areas that

needed attention to make them more easily cleanable. Medicines were managed in a safe way but there were some shortfalls in relation to medicine recording.

People who could express a view told us they received a "good service". Before they moved to the home their needs were assessed to check if the home could provide the right care for them. Staff had opportunities for relevant training, although the induction of new staff and agency staff did not always show they were supported into their new role.

The assessments about some people's capacity to make their own decisions was not always clear. Staff were going to have more training to help them understand the Mental Capacity Act 2005.

People now received the right support with their nutrition and hydration needs. Risks to people's nutritional well-being were now assessed and managed. People said they enjoyed the meals and the quality of food was very good.

People and relatives told us staff were kind and caring. Staff were respectful and helpful when supporting people. There were friendly relationships between staff and the people who lived there.

There was a welcoming atmosphere in the home. Staff supported people to make their own individual choices and communicated with them clearly and sensitively.

Following concerns by the local authority about care records being out of date, senior staff were now reviewing and updating everyone's care records. The records that had been updated were recorded in a personalised and clear way. This work was still on-going during the inspection.

There were activities provided each day and the people who took part said these were enjoyable. There was not always much interaction with people who spent time in their bedrooms and little to demonstrate their engagement in activities. We have made a recommendation about this.

People were asked for their views in surveys and at meetings. They had information about how to make a complaint and concerns that people had raised were acted upon. Staff felt they could talk with the acting manager and said they were approachable.

Staff told us that the atmosphere improved. They enjoyed working at the home. Staff said they had more direction and guidance now. Communication between management and the staff team had improved. This was evident from the morning briefings held by senior staff and the acting manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some concerns had not been reported in line with safeguarding protocols.

Staff were not always able to answer call bells in a timely way so we have made a recommendation about this.

Medicines were managed safely but some medicine records were incomplete.

The home was warm, comfortable and maintained in a safe way. But some areas were difficult to keep clean.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received relevant training but some new and agency staff would benefit from more induction support.

Some people's assessments about their capacity to make their own decisions were unclear.

People were supported with eating and drinking in a way which supported their choices and health.

Staff helped people to access health care services when they needed them.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were kind, caring and friendly.

People were given time to go at their own pace and were not rushed when being assisted.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's records were out of date so they did not always include the right guidance for staff about each person's specific needs. This was being addressed at the time of the inspection.

There was not always sufficient engagement with some people who spent time in their rooms and they were potentially socially isolated. We have made a recommendation about this.

People and visitors were encouraged to comment on the home and there was a complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider's quality assurance checks had not been effective in identifying and improving several shortfalls including safeguarding and accident reporting, infection control, medicines records, care records and training.

There was a registered manager in post. They were not present at the time of the inspection. An acting manager was managing the service.

Staff told us that the atmosphere in the home had recently improved and they had clearer direction.

Elm Bank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This responsive inspection was prompted by concerns received from external health and social care services. An unannounced visit took place on 23 October 2018. This meant the provider and staff did not know we would be coming. A further visit took place on 24 October 2018 which was announced.

The inspection was carried out by an adult social care inspection manager, inspector, assistant inspector and a specialist nutritional adviser.

Before the inspection we reviewed information available to us about this service. We reviewed safeguarding alerts and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We contacted commissioning, safeguarding and quality officers from the local authority. We also spoke with a healthcare professional who had recently visited the service during our inspection.

During the visits we spoke or spent time with 10 people and two relatives. We spoke with the three senior care workers, two care workers, catering staff, housekeeping staff, maintenance staff, activity staff, the acting manager and regional manager.

We used the Short Observational Framework for inspection (SOFI) SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed seven people's care records and four staff files. We also checked records relating to the management of medicines, complaints, training and how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

The service had not always reported concerns in line with safeguarding protocols. These included reports of alleged abuse and a lack of reporting of unwitnessed accidents resulting in injuries. Some of these incidents had not been reported to the provider or relevant agencies, so no investigation or action had taken place. This meant vulnerable people had not always been protected by the service because safeguarding adults' procedures had not been followed.

Since October 2018, the acting manager had reviewed incidents, such as unwitnessed injuries, and made sure that these were appropriately reported and any actions were taken. Meetings had been held with the staff team to provide guidance about when to refer accidents and to report any falls to the person's GP and care manager. We saw this guidance was reiterated at morning meetings held between the acting manager and senior members of staff.

The provider had a safeguarding policy and staff completed self-learning in protecting people from abuse in the form of a short on-line training session. Staff had access to the provider's procedures in safeguarding adults and whistleblowing (reporting poor practices). As a result of the recent concerns, the local authority had arranged to provide group training for staff in safeguarding adults to make sure staff were clear about how to report incidents.

The people we spoke with said they safe at the home. For example, one person commented, "They're all nice people and they look after us. Yes, I feel safe here."

The home did not fully meet the standards for infection prevention and control. We saw some areas that couldn't be kept hygienically clean. For example, there were some broken tiles behind the toilet bowl in one shared toilet, the flooring was lifting behind the toilet in one bathroom, there was perished sealant around toilet pedestals and exposed wood shelving in a sluice room that was not impervious to spillages. Cleaning trolleys were unclean and rusting. The clinical bin in one sluice room was broken and there were broken pedal-bins in some toilets. This meant staff and people would have to handle the bin lids to dispose of waste. The acting manager stated that new bins were on order and the premises issues would be addressed by the home's maintenance staff member.

During the week of this inspection there was only one housekeeping staff on duty to clean the home as another staff member was on holiday. This was a large, three-storey building to maintain. There were no poor odours in the home, but with only one staff it would be difficult to achieve a deep clean. The acting manager explained that a new part-time member of housekeeping staff had been appointed, subject to recruitment checks, which would help to cover staff absences.

The provider used a dependency tool to calculate the level of support each person required and this was used to calculate the staffing levels. However, it was not clear if people's dependencies were accurate because their care records were not always correct and some people's dependencies had not been updated in three months. The care staffing at the time of this inspection was three senior care workers and four care

workers to cover the three floors. These staffing numbers were not unsafe, but we noted on a few occasions that call alarms sounded for several minutes before being answered. On one occasion the call bell sounded for 15 minutes and was eventually answered by the regional manager. At times some staff carried out telephone calls and paperwork before assisting people. These points were raised with the acting manager who agreed to make sure staff prioritised people's assistance first.

It is recommended that the provider review the staff levels and deployment of care staff based on reviewed dependency assessments to make sure people received timely assistance.

There were vacancies for senior care workers, which were being covered by acting seniors and agency staff. The same agency staff were used for continuity. The acting manager said the staffing situation had been "manic" for a few months but that staff had been supportive and wanted stability in the home. There was an intention to recruit bank staff above base level so that future sickness and holidays could be more easily covered.

Recruitment processes were in place to make sure new staff were suitable to work in the care home. These included application, interviews and reference checks. The provider also checked with the Disclosure and Barring Service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people.

Staff were trained in safe handling of medicines and their competency was periodically checked. Medicines were delivered by a pharmacist and staff recorded the incoming and disposal of medicines. Staff recorded when they had given people their medicines on the medicines administration records (MARs). The administration and stock checks of medicines were managed in a safe way. There was a daily count down and check of medicines to make sure the correct amount had been given and correct amounts were left.

We saw there were some shortfalls in relation to medicine recording. For example, in the sample of medicines records we looked at staff were using inconsistent or incorrect codes to record whether people had taken their regular and 'when required' medicines. Where people could have a variable dose of medicines, such as one or two tablets, staff had not always recorded which dose they had administered. One person who was prescribed 'when required' pain relief had been administered this for 31 times in the past three weeks but there was only one record of why this had been given on the back of the MARs. There were at least three occasions over the past year when controlled medicines had been signed by only one member of staff instead of two. These issues were contrary to best practice guidance and to the provider's own medicine's policy. We also noted on some days the ambient temperature of the medicine cupboard had not been recorded to make sure it was within a safe range for the storage of medicines. We reported these recording issues to the acting manager for attention.

These incomplete records were a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Good governance.

There were relevant risk assessments in place to show how people should be supported safely. These included risk assessments for people's mobility and people who were at potential risk of falls. We checked the moving and handling equipment across the service including baths, hoists and other lift equipment. Those that were in working order and had been serviced within the last twelve months. Staff were aware of who required assistance with the hoist and what types of slings were used to move people safely. The home had a staff champion in moving and handling. They said, "All staff have received the training and competencies are regularly reviewed. Staff are more confident using the equipment after receiving practical training."

There were fire safety plans in place and staff had received evacuation training. Equipment was tested regularly including alarms, firefighting equipment and emergency lighting. Personal emergency evacuation plans (PEEPS) were in place which detailed the level of support people would need if they had to be evacuated from the service.

The maintenance records in relation to the overall premises safety demonstrated that the relevant checks were being carried out. The service had received recent electrical and gas safety inspections. The service employed a maintenance member of staff who carried out routine safety checks, for example hot water temperature checks.

The acting manager carried out regular analysis of accidents and incidents to check for any trends and to check that action was being taken to minimise the risk of reoccurrence. For example, people who were now regarded as at high risk of falls were provided with sensor mats, mobility equipment and additional observation checks. The acting manager was using these examples at staff meetings to support a 'lessons learned' approach by staff.

Requires Improvement

Is the service effective?

Our findings

People's needs were assessed before they started to use the service. Assessments were carried out to identify people's support needs which included information about their medical conditions, mobility, dietary requirements, safety and other aspects of their daily lives.

The people who could express a view about the service they received said they felt they were assisted in the right way by helpful staff. Their comment included, "I am well looked after here" and "the service is good".

At the time of this inspection a training matrix showed the majority of care workers had completed essential on-line training in health and safety subjects such as food hygiene, fire safety and first aid.

New staff had not always been fully supported with induction into their roles. The acting manager stated a request had been made to the training department for coaching support to address a gap in the induction training of four staff. These staff had commenced employment over the past two years but had still not completed the Care Certificate. (The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours that should be covered if staff are 'new to care' and should form part of a robust induction programme.) Arrangements were now being made to identify a coach to support those staff. We also noted that a new member of housekeeping staff had started working at the home three months earlier but there were no records of any probationary meetings or supervision sessions with them to check their progress.

The home had recently used agency staff to fill several care shifts. There were records of the employment profile and induction of some of the agency staff. However, there were no profiles or induction records for three of the agency staff on shift during the week of this inspection. The acting manager stated this would be addressed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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.

We saw mental capacity assessments had been carried out for some people where specific decisions had to be made about their care and where they lacked capacity. We also found a small number of mental capacity assessments were contradictory or unclear. For example, one person had been assessed as having capacity to consent to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). However, their care plan stated they did not have capacity to make such significant decisions. There was also an example where a person's

capacity had been assessed without any specific decision to be made, which indicated some staff were unsure of MCA. One person's care records stated that a DoLS application had been made because the person "may get lost and not find their way home again", which indicated that the staff member was unclear about DoLS. The acting manager confirmed that arrangements had been made for staff to attend group training in MCA and DoLS in the near future to improve their understanding of this. Some people's care records referred to their relatives having legal power of attorney (LPA) to make decisions on their behalf, but there were no copies of their LPA status to confirm their right to do this. The acting manager stated that relatives with legal power of attorneys would be asked to provide the confirmation copies of their right to make decisions for those people.

We saw the home's DoLS register of applications that had been submitted to the supervisory authority. Some people's DoLS applications had been submitted over a year ago but due to a backlog in the local authority these had not yet been processed. It was difficult to tell from the home's register what the progress of applications was and the acting manager stated they were going to contact the authority for clarification.

All the people we spoke with were complimentary about the quality and choice of meals. For example, their comments included, "The food is champion", "the meals are very good" and "there are no complaints about the food". People said they were now being offered cooked breakfasts which they enjoyed and felt the range of meal choices was good. We tasted a lunchtime meal and found it was full of flavour.

Prior to the inspection there were concerns that some people were losing weight, food records were incomplete and the home's weighing scales were broken. During this inspection we found people's nutritional and hydration needs were being met, food and fluid records had improved and new seated scales had been purchased. Nutrition screening assessments were completed monthly, and weights of all residents were being completed weekly for four weeks to check for any significant changes. We saw that the weight loss of one person who was at high risk of malnutrition had reduced and their weight was stabilising. People who were at risk of losing weight were provided with fortified diets.

The four-week menus gave the opportunity for people to have five portions of fruit and vegetables each day. Food records showed exactly what people had eaten and, in most cases, whether this was fortified or not. We saw that any recommendations from dietitians and therapists were included in people's care records and it was evident that their advice was being acted on. Staff understood the different altered food textures that people needed and their meals were the correct consistency for them.

People who required support to stay hydrated had fluid charts in place. Their individual daily target on their fluid chart matched the targets set in their care plan. Staff used a handover book to alert the next shift if someone had not had enough to drink along with what action was needed to encourage them to drink more.

There were cold drinks dispensers in lounges and we saw people had cold drinks in their own bedrooms. There were dining rooms on each floor but no facility for staff to make people hot drinks. People mainly got a hot drink at set times when the tea trolley came around or at mealtimes. For example, when one person repeatedly asked for a cup of tea they were told the tea trolley would be coming around soon, but it was 50 minutes before the person received their drink.

There were some environmental adaptations to support people with mobility and dementia needs. For example, there were assisted baths which were fitted with chair hoists. Until recently the assisted baths on two floors had not been working properly. One had been out of action since December 2017. Although there

were showers on each floor this meant people who preferred bath would have to be supported to another floor and this would have affected staffing numbers available to support the remaining people. When concerns were raised by the local authority about the broken baths, one bath was fixed and the other bath was due to be fixed within the next few weeks following the inspection.

Some bedroom doors were not fitted with dorguards (devices that allow the door to be propped open but close it in the event of a fire alarm). The bedroom doors were very heavy and difficult to pull open. These would be impossible for people with walking aids to operate independently. The acting manager stated that alternative fire-safe devices were being sought for these doors.

The corridors of the middle floor had been provided with items of visual and sensory interest for people living with dementia. These included street scenes and different items of interest such as a library, budgies and soft toys. There was an intention that the lower floor would also be designed for people living with dementia in the future. Around the home there were some picture signs to support people to get around and find bathrooms. There were also some picture menu cards to help people make meal choices. There was coloured crockery to support people living with dementia to see their meals.

There were references in care records to people's access to health care services. Care records contained details of referrals to other health care professionals such as GPs, speech and language therapists and district nurses. There were improved reports of actions taken when people had a fall or accident. For example, their GP and social worker were now being informed of any accidents and injuries.

Good

Is the service caring?

Our findings

The people who were able to express a view about the service they received said they were assisted in a caring way. For example, one person told us, "They (staff) are so lovely." Another person told us they really liked it here and said "everyone is so pleasant". A relative told us their family member was "settled here". Another visitor commented, "The staff are friendly."

During the inspection we observed a number of occasions when staff assisted people in kind and compassionate ways. We saw when one person was upset a care worker demonstrated a very caring approach and stayed with them until they settled. We saw several occasions where staff were helpful and encouraging towards people, particularly at mealtimes.

When staff did interact with people it was in a friendly, valuing way. For example, when a person asked an agency staff if they had had a good day, the agency staff replied, "It's better for being able to spend it with you." We saw people's mood lifted when they chatted to staff and they became increasingly engaged with staff and other people around them due to these positive interactions.

A relative described how staff had been especially supportive when their family member had been unable to make it to a family wedding. The relative told us, "Two of the care staff went over and beyond to make the day extra special for my [family member]." The person commented, "It really made my day."

One person who was going home after staying for a short break had several positive comments to make about the service they had received. They told us, "It's been brilliant. I've been spoilt rotten and the staff are all really lovely."

People were offered choices through the day such as activities and meals. People chose from two main dishes at the time of the meal, and were encouraged to have as much as they wanted. During a teatime meal we saw staff asked each person individually which choice they would like and took lots of time to explain what a 'quiche' was. Staff brought the different meal choices to each person to look at so they could make an informed choice.

Staff bent down to people's eye level so they could have a face-to-face conversation while they made their minds up about their choices. Staff used gentle humour and chatted in a clear, unrushed way so that people could understand and join in. The patient, positive attitude of staff made people relax and made the meal time a very sociable and pleasant occasion.

People's independence was encouraged where capabilities allowed. For example, some people were able to go out into the local area and this was supported by the service. People staying on the lower ground floor had patio doors out onto secure garden areas if they had good mobility to manage this.

People's privacy and dignity were respected. We saw staff always knocked on people's bedroom doors before entering their bedrooms. People were supported to be well-presented and appropriately dressed.

People's care records reflected any gender preferences when being assisted with personal care. For example, one person's support plan about washing stated, "[Name] has no preferences to assistance from male of female carers to wash and dress but would like assistance from female carers only when having a bath."

A small number of people had visual impairments that meant they could not read standard-sized print. Their families managed their mail for them. The provider had information that could be made available in accessible ways, for example in large print.

The home had provided a list of local advocacy services in each person's file. An advocate acts on behalf of a person to impartially represent their views. No one was accessing any formal advocacy service at the time of our inspection but staff knew how to arrange this if necessary.

Requires Improvement

Is the service responsive?

Our findings

Following recent concerns raised by the local authority about people's care records not matching their needs, the provider had put an action plan in place to address this. All care plans were being reviewed, and rewritten where appropriate, by senior members of staff who were familiar with people's individual needs and capabilities. This work was on-going during the inspection and there were plans for it to be completed within two weeks.

In the meantime, we identified some people's records that had not been reviewed were out of date because people's needs had changed. For example, one person's capacity care plans stated the person could make simple, everyday decisions. However, some months ago the person had become unable to do this and staff now made all their decisions. The care plan had not been updated at that time. Another person's records stated they required a pureed diet because of their risk of choking. However, the person had lost weight so the speech therapist and relative had agreed that the person could have a less pureed meals to encourage them to eat. This had been successful, but their care records still referred to the pureed diet which was incorrect.

Although we could see that action was being taken to update each person's care records, this work had not been completed and agency staff could potentially use this information to provide the incorrect or inconsistent support. We considered that an effective system had not been in place previously to ensure care records were well-maintained.

Regular staff had good knowledge of people's preferences and well-being. In discussions the staff we spoke with understood people's individual needs and were able to explain how they supported them for example, with their mobility or nutritional needs. People's care files contained a one-page summary about each person and a 'This is Me' record which included a personal profile and life history of the person.

A relative commented the service "was a lot better recently". They felt that staff were familiar with their family member's needs and commented, "Communication is good and they [staff] always keep me well informed."

The provider employed one activity staff to arrange social events and activities across the three floors. The activity staff had a lot of engagement with people who lived there, particularly on the top floor where several people spent time in the lounge and where a small number of local people came for day care.

The weekly activity programme was displayed on each floor but we saw people were asked if there was anything else they would rather do, so they were involved in choosing the type of game or quiz. The week of this inspection included board games, quizzes, reminiscence, jigsaws and gardening. We saw care staff did spend some time with some people on a one-to-one basis as well as in small groups engaging in activities such as playing dominoes. There were also visits from musicians and entertainers as well as local church services.

People had mixed views about the activities. One person told us they liked "doing exercises and playing games". Another person felt the activities were "too repetitive". One person said they "don't get to go out much".

Some people preferred to spend time in their rooms. This was respected. But it also meant they were quite isolated at times, especially if there were no staff visible or if their bedroom door was not fitted with a holding device so they could not see other people passing by. At the last inspection we recommended that activities were reviewed to make sure they took account of people who required one-to-one attention. At that time, the registered manager and regional manager said they would look at staff deployment to make sure people had attention in their rooms. During this inspection we saw that some people did have individual time with staff but several other people who stayed in their rooms did not.

We recommend that the provider monitors the engagement and activities provision for people who remain in their rooms to make sure their social and emotional wellbeing is met.

There was information for people and their relatives about how to make a complaint and the service kept a log of any complaints received. There had been three complaints in the past year. These had been formally recorded, including the details of the complaint, the investigation and the findings. Two complaints had been fully investigated and the third was being finalised by the acting manager. In this way, the provider intended that complaints were taken seriously and were acted upon.

End of life care was provided when necessary and staff had received training in how to support people as they neared the end stages of their life. Staff worked with other care professionals to provide palliative care for people if the home was their preferred place of care and if the appropriate care could be provided.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems had not always been effectively applied so had not always ensured that satisfactory standards were achieved in this home.

'Real time' checks and audits of the service were carried out on a computerised management system. This should allow management staff and the provider to identify any areas for action and monitor whether these had been completed. However, these had not been robustly completed so had failed to identify the shortfalls that required actions. For example, infection control audits that had been carried out during June to August 2018 had all scored above 90%. However, an audit carried out in October 2018 by the acting manager had scored 14.76%, even though there had been no change to the premises or staff practices. A visit by the infection prevention and control nurse in September 2018 also identified a number of concerns regarding infection control practices. Some of these issues were still apparent six weeks later during this inspection, for example several pedal bins that were broken. The acting manager stated replacement bins had been ordered.

Some people's care records no longer reflected their needs and were in the process of being updated. However, this issue had not been identified by the provider's own monitoring systems, instead it had been raised as a concern by the local authority. The audits carried out by home management team had scored people's care records at achieving over 90%. The presence of outdated information within the service user's care plan demonstrated a lack of effective systems for reviewing care plans as the shortfalls would have been identified and addressed by an adequate audit procedure.

Most audits competed contained only 'yes', 'no' or 'not applicable' responses and had no detail of which records had been viewed. Where a negative response was recorded there was no action plan of how and when this should be addressed.

The provider's system used to record incidents and events (called datix) included reports of a number of unwitnessed falls and injuries but, prior to October 2018, there were not always records of the actions taken and outcomes. These shortfalls had not been identified by the provider's monitoring systems, instead had been raised by the local authority.

There were gaps in training for new staff in the Care Certificate which had been on-going for some considerable time. A bath on one floor of the home had been broken from December 2017 until October 2018. Although the registered manager had previously submitted a request for a replacement bath, this was not progressed until it was identified as a concern by the local authority.

These matters meant the systems and processes to assess, monitor and improve the quality and safety of the service were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance.

Senior managers had compiled an action plan to address these shortfalls and the concerns raised by the

commissioning authority. The acting manager had prioritised the significant areas of safety concerns for example, nutrition and falls prevention and these areas had improved. There were a number of actions yet to complete. These would then need to be tested for sustained improvement.

The registered manager was not at the service at the time of our inspection. A Resident Experience support manager was the acting manager of the service in the registered manager's absence. Staff spoke positively about the leadership of the acting manager and improvements that were being made. Staff felt they were being given clear direction about expected practices. Morning meetings were held with senior staff and heads of department which was an opportunity to check the well-being of people and any issues within the home that required actions. There was good communication between staff throughout the day.

People and relatives were invited to attend meetings where they could share their views about the service. The last one had been held in October 2018, was largely positive and mainly included discussions about activities. People had commented they would like more integration with the local community and local schools.

An electronic system was also available for people, relatives and visitors, including professionals, to share their views about the service including any concerns. This involved completing a survey on an electronic device (iPad). This provided real time feedback for the provider so they could address any issues raised. There was a display board in the hallway of 'you said, we did' suggestions by people and any actions taken. For example, it stated fresh fruit was now available in all lounges as suggested by people. However, this was not the case and was not usual practice (as fruit was provided on the tea trolley instead). The acing manager agreed this was misinformation and would remove it.

Staff also had opportunities to attend staff meetings. There had been two meetings in past the past two months to discuss the concerns raised by external professionals and the current acting management arrangements. This provided opportunities for staff to discuss expected practices as a team. The staff we spoke with said they "enjoy working here" and "it's a nice place to work". One staff member told us, "The staff are very nice. We work together as a team and support each other."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA (Regulated Activity) Regulations 2014 Good governance The provider's quality assurance systems had not been effectively applied in order to assess, monitor and improve the quality and safety of the service. Medicines records were incomplete or inconsistent. Regulation 17(2)(a) and (c)