Akari Care Limited

Wellburn 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?	**Good**
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 3 October 2017. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

The service was last inspected in October 2016 and rated 'requires improvement.' We found breaches of Regulations. This was because improvements were needed in medicines and audits failed to highlight issues and concerns regarding medicines. Following our last inspection the provider sent us information, in the form of an action plan, which detailed the action they would take to make improvements at the home.

Since receiving that action plan the registered manager left the service. A new manager was appointed who came to post in July 2017. The new manager was starting to make improvements but had only been in post two months, therefore a lot of the improvements had just been implemented.

At this inspection we found that medicines were still not being administered safely. Audits had started to take place and highlighted some of the concerns we raised but not all had been acted upon.

Wellburn House is a 90 bedded purpose built two storey care home. It has two units; the ground floor unit for people with personal care needs and the first floor unit for people living with dementia. All bedrooms have en-suite facilities and there is a large courtyard garden. At the time of inspection there were 44 people using the service.

There was a manager in place who was in the process of being registered with the Care Quality Commission since 2015. 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.

Risks to people arising from their health and support needs and the premises were assessed, and plans were in place to minimise them. Risk assessments were regularly reviewed to ensure they met people's current needs. A number of checks were carried out around the service to ensure that the premises and equipment were safe to use.

There were enough staff to meet people's needs. Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. Staff were now given effective supervision and a yearly appraisal.

Staff understood safeguarding issues and were aware of the whistleblowing policy [telling someone] if they had concerns.

Staff were in the process of receiving training to ensure that they could appropriately support people, and

the service used the Care Certificate as the framework for its training. Staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) training and clearly understood the requirements of the Act. Best interest decisions were made appropriately with the person and family were fully involved. This meant they were working within the law to support people who may have lacked capacity to make their own decisions. The manager understood their responsibilities in relation to DoLS.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for. People told us they had a choice of food and everyone enjoyed what was on offer.

We saw evidence in care plans to show the service worked with external healthcare professionals to maintain people's health.

We found the interactions between people and staff were kind and respectful and people were offered choice throughout the day.

Procedures were in place to support people to access advocacy services should the need arise. At the time of inspection no one was using an advocate.

Complaints were acted on using the guidance of the services complaints policy. However the outcome to show the complainant was happy was not recorded.

Staff had a clear understanding of people's needs and how they liked to be supported. People's independence was encouraged without unnecessary risks to their safety. Support plans were well written and specific to people's individual needs.

The manager was a visible presence at the service, and was actively involved in monitoring standards and promoting good practice. People, relatives and staff felt confident in the manager. Feedback was sought from people, and relatives to assist in this. The service had quality assurance systems in place. However, they were not effective in identifying the issues we found.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of concerns around medicines and the lack of audits. You can see what action we told the registered provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines were not always managed safely for people and records had not been completed correctly.

Risk assessments were in place and included enough detail to mitigate the risks.

Recruitment procedures robust and there were enough staff employed.

Is the service effective?

Good

The service was effective.

Staff were fully supported with supervisions and appraisals.

The manager and staff knew their responsibilities under the Mental Capacity Act.

People were provided with a healthy diet.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People were happy with the level of support they received and felt staff were kind and caring.

Staff knew how to treat people with respect and dignity.

People were encouraged to be independent where possible and given the right level of support when they needed it.

Is the service responsive?

Good

The service was responsive.

People's care records contained information to guide staff on the care and support to be provided.

People had access to a wide variety of activities.

There was a clear complaints policy which the service adhered to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager carried out quality assurance checks but audits had not identified the issues we found.

Survey data was used to improve the service delivery.

Staff meetings were held regularly and staff spoke positively about the support they received from management.

Wellburn 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 3 October 2017. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. At the time of our inspection 44 people were using the service.

The inspection team consisted of one adult social care inspector, one pharmacist inspector, one specialist professional advisor and an expert by experience. A specialist professional advisor is someone who has professionalism in this area such which was a nurse and an expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered provider was asked to complete a provider information return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR in a timely manner.

We also contacted the local authority commissioners for the service, the local authority safeguarding team and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 14 people who lived at the service and four relatives. We looked at seven care plans and medicine administration records (MARs) for 10 people. We spoke with nine members of staff, including the manager, the deputy manager, care staff, ancillary staff, the administrator and the cook.

We looked at six staff files, including recruitment records.

We also completed observations around the service.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were handled and found that the arrangements were not always safe.

The provider was using an electronic medicine system and whilst staff had been trained in using the system we found that records relating to medicines were not completed correctly, which placed people at risk of medicines errors. We found that when people had not taken their medicines, for example if they refused or did not require them, the reason for not taking the medicine was not always clearly recorded. This meant that administration records did not provide a clear picture of all medicines a person had taken or the reasons why they had not.

Several people were prescribed creams and ointments. Care staff applied many of these as part of personal care or when people first got up or went to bed. We saw the home had records including a body map that described for care staff where and how often to apply these preparations. However, for some creams, there was no guidance or records in place and other records were not fully completed. We also saw that some records showed that staff had not applied some creams at the frequency prescribed. These records help to ensure that staff applied people's prescribed creams and ointments appropriately.

For medicines that staff administered as a patch, for example for pain relief, a system was in place for recording the site of application. However, for the two people whose records we looked at there were incomplete records in place to show where the patch was applied, and the application site was not rotated in line with the manufacturer's guidance to prevent side effects. This meant we could not be sure people received their medical patches in line with what had been prescribed.

We found the individual guidance, to inform staff about when medicines prescribed to be given only when needed, was not always available was not person centred or had not been updated when a medicine was changed. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way. In addition, we found staff did not always record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. Two people took when required medicines every day but this had not prompted a review of treatment in line with the provider's medication policy.

Four medicines for two people and one cream for another person were not available. This meant that appropriate arrangements were not in place for ordering and obtaining people's prescribed medicines in a timely manner. This meant people did not always receive their prescribed medicines when they needed them.

One person had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw that the GP had authorised covert administration (adding medicines to food), however it was not clear how this would be done or whether advice had been sought from the pharmacist. This person also had two medicines listed on the medicine record that was not listed on the GP authorisation. This information is necessary to ensure people were

given their medicines safely and consistently when they were unable to give consent.

We looked at how medicines were stored. Appropriate checks had taken place on the storage, disposal and receipt of medication. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered, however they were not stock checked weekly in line with the provider's medication policy. Two eye drops, which have a short shelf life once open for one person, were not marked with the date of opening. This means that the home could not confirm that they were safe to use.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the provider had completed regular medication audits and identified some issues however these that had not identified all of the issues we found.

These findings evidenced a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014 (Part 3)

People we spoke to said they felt safe living at the service. Comments included, "It's alright living here. The staff are friendly I have no problem with anybody. I feel safe here as anywhere else. There are enough staff, they will talk and chat with you. They treat me well.", "I feel safe here." and, "I feel safe here, there's never any mistakes with the medication."

Relatives we spoke with said, "There are enough staff here, my relative is safe living here. The staff are good and there is a good atmosphere."

We saw risks arising from people's health were assessed and a detailed plan was in place to mitigate the risks. Risk assessments were in place for people's mobility needs, diet and nutrition, bed rails and lap belts on wheelchairs as well as risk assessments for refusing to go to bed. Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped identify the level of risk. For example, one person's risk assessment to reduce the risk of choking detailed the actions to be taken to reduce the risk, for example for food to be cut up into smaller pieces and to remind the person to chew their food. Another person's risk assessment described how they should be reminded to use their walking frame and to wear the correct fitting shoes. Risk assessments were reviewed on a monthly basis or more frequently if needed to ensure they reflected people's current needs.

Risks to people arising from the premises were assessed and monitored. Fire and general premises risk assessments had been carried out. Required certificates in areas such as gas safety, electrical testing and hoist maintenance were in place. Records confirmed that monthly checks were carried out of emergency lighting, fire doors, water temperatures and water flushing of unused rooms.

A Personal Emergency Evacuation Plan (PEEP) was in place for each person, documenting the required support they needed to leave the premises in the event of an emergency. This showed that the provider had taken appropriate steps to protect people who used the service against risks associated with the home environment.

We saw the provider's business continuity plan which detailed what to do in the event of having to evacuate the premises due to an emergency such as flooding or fire. The plan also stated what to do in the event of staff shortage or loss of electric. This showed us that contingencies were in place to keep people safe in the event of an emergency.

Accidents and incidents were recorded accurately. The new manager had developed a document to start analysing the accident and incident relation to date, time and location to look for trends. Although no trends had been identified records showed appropriate action had been taken by staff and there was documented evidence of involvement of external healthcare professionals such as the falls team. Where people were a falls risk there was a step by step flow chart of what staff were to do in the event of a fall from immediate needs, recording needs and reporting needs.

Staff we spoke to had a good understanding about safeguarding and whistleblowing [telling someone]. One staff member said, "I would whistle blow with no hesitation if I was unhappy about something. We have policies on this and I know how to take it further if need be."

We observed there were enough staff on duty. On each floor (up and down) there was a senior care worker and three care workers. People, relatives and staff all said there was enough staff on duty at all times. Comments included, "There are enough staff, they will talk and chat with you. They treat me well." and "There is enough staff here, no problems." The manager used a dependency tool to calculate how many hours were needed and this was reviewed monthly or as people's needs changed. One staff member said, "There is enough staff but at times when there is sickness we have to use agency, but that is improving." The manager said, "We are reducing our need for agency workers, I would prefer to use our own staff. " We saw evidence of the information the service requested about agency staff which included training records, evidence of current disclosure and barring (DBS) checks and permission to work in the United Kingdom if applicable. Each agency staff went through an induction on their arrival which consisted of tour of the home, alarm system, location of different rooms, the security system, telephone answering, first aid and staff room.

Robust recruitment procedures were in place to ensure suitable staff were employed to work at the service. Applicants completed an application form in which they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service (DBS) check was carried out before staff were employed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with children and vulnerable adults. The manager said they request updated DBS checks every three years.

We found the service was clean and tidy. There was personal protective equipment (PPE) available when required such as gloves and aprons.

Good

Is the service effective?

Our findings

We saw that not all staff training was up to date. The manager had recognised this and all required training was booked in or had just been completed and were awaiting certificates. We were provided with a training calendar that recorded all upcoming training. The provider had set up with a contract with a new training company who came and provided face to face training for all staff. Staff had just received medicine training on the 20 September 2017, however, some staff could not answer some basic questions we asked. We discussed this with the manager who said she had identified this and sent out a set of medicine questions to check understanding. The manager had only just received these back and not had chance to mark them.

We recommend the provider makes sure all staff have up to date relevant training in place.

One person who used the service said, "They [staff] are all well trained here. Sometimes you get new staff and they get an induction."

We saw evidence to show supervisions were taking place and the manager had a supervision matrix to show when a staff member's next supervision was. The service's supervision policy stated that they were to take place four times a year and we saw the service was on track to acheive this.

Staff also received a yearly appraisal where they discussed how the last year had been, what the staff members achievements were, the best part of the job and what support was needed for the coming year and their development.

New staff undertook a twelve week induction programme, covering the service's policy and procedures and using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected.

We saw evidence that people were weighed either weekly or monthly to monitor their nutritional health. Where weight loss had occurred, appropriate referrals were made to dieticians and the speech and language therapy (SALT) team. One person had a visit from the dietician the day before inspection and due to them losing weight a pureed diet was suggested as they had difficulty chewing. The care plan and kitchen notifications had been updated to reflect this change in need.

We observed staff supported people discreetly where needed, cutting food up and offering tabards to cover clothes. Staff were very attentive, constantly talking to people and encouraging them to eat as well as offering plenty of drinks of their choice which included, blackcurrant, orange or sherry.. Staff knew people's likes and dislikes. For example, one person liked their food to be very hot, so once it was on the plate the staff put it in the microwave to heat it up. The person said, "I like it so hot, I cant be doing with it warm." The relative of this person said, "The staff always put [relatives] food in microwave as they like it very hot, nothing is too much trouble for them."

We observed people were offered large wet wipes to enable them to clean their hands before the meal. Dementia friendly brightly coloured cups and plates were used where required. A recent study by the Alzheimer's society showed that people living with dementia ate 25% more food from a coloured plate rather than a white one. the Alzheimer's society states, "Use colour to support the person - the colours of the food, plate and table should contrast and be plain (eg a green table cloth, a red plate and mashed potato). Avoiding patterned plates is important."

Drinks and snacks were readily available throughout the day. We saw staff offering people crisps and/or biscuits mid morning. People were also provided with yogurts in the morning and afternoon.

People were complimentary about the food. Comments included, "I love the food, there is always plenty of choice, " "The food is lovely, I just want a jacket potato today with butter. I sit and have lunch with my friend, we are very good friends" and "The food is very good, I enjoy it. I love the vegetables, I'm a good eater." Further comments included, "The food is nice here, there's plenty of it." and "I'm diabetic, the food is absolutely lovely. There's plenty of choice. If you want something different they will make it for you."

We observed a board in the kitchen which provided details on people's special dietary requirements such as diabetic, pureed or fork mashable. The chef said, "People have said they want more sandwiches at teatime, therefore we do one hot dish and one cold. We always try new things and always cook something different if asked, we are very flexible." The chef went onto explain that one person liked their breakfast at 6am, their lunch at 11:30 and tea at 15:30, this was accommodated.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The aim of DoLS is make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The manager and staff had an understanding of the MCA and the DoLS application process. At the time of our inspection there were 24 people subject to a DoLS authorisation. There was evidence in the care files what staff were to do if someone needed a hospital admission and had a DoLS in place.

We saw evidence of best interest decision being made for people who required bed rails, lap belts on wheelchairs and medicine administration. We saw in care plans that staff were to encourage people to make everyday decisions.

The manager had introduced new forms for consent and some had more information than others. We found consent needed to be more decision specific in some areas. For example consent to staff taking over their care and wellbeing but it could be the person may be able to choose their own clothes but need support to dress. The manager agreed to update the records.

People were supported to access external professionals to maintain and promote their health. Care plans contained evidence of referrals to professionals such as GPs, the district nurse, dieticians, speech and language therapist, dentists and opticians.

We saw that signage throughout the service was dementia friendly. The corridors were themed to aid people's orientation, for example there was a sea side and fifties style and there were tactile items attached to the walls. We also saw a nostalgia lounge was about to open with items such as an old analogue television, a tea set, grandfather clock and fire place. The manager said, "We are also planning a 'men's shed area' upstairs in an unused space together with a coffee shop style area." One relative said, "My relative is very happy here, they [provider] painted their room in their favourite colours of lilac and lavender, nothing is too much trouble."

Good

Is the service caring?

Our findings

People told us they were cared for by kind and friendly staff who were attentive. One person said, "The staff are friendly I have no problem with anybody." Another person said, "It's alright I'm happy here. The staff are nice, if you want anything they are there." And another person said, "I love living here because of the company and the carers. The staff are very caring, and there's always enough of them." One person said, "I'm content here. You get to know people. The staff are nice, people help each other. Yes, I'm very happy here."

Relatives spoke positively about the care provided and told us they were made to feel welcome whenever they visited. One relative said, "I think the staff are wonderful. They meet my relatives needs and more. The staff go the extra mile. The staff team seem to get on well together. There is a consistency of carers coming to see [relative] to deliver care. We all visit every day, there is nothing I would change." Another relative said, "Staff will laugh and joke and everyone smiles. I've never once seen anything but understanding."

Staff knew people well and there were warm, positive and caring interactions between staff and people who used the service. For example, there was friendly chatter amongst people and staff which made the environment homely. People shared jokes with staff and staff engaged people in conversation by crouching down to speak to them at eye level. Staff worked together to provide a pleasant atmosphere, speaking to people in a thoughtful and respectful manner and were well aware of their roles and responsibilities.

One staff member said, "I feel more valued by the residents. I think the service meets peoples needs, when the staffing is at the right level." Another staff member said, "I love working here." And another staff member said, "We always ask how people are and are caring with their needs. We always remember this is their home and we are working in their home."

Staff encouraged people to maintain their independence. One staff member said, "I always encourage people to help themselves but offer prompts." We observed staff prompted people to be independent throughout the day.

Staff promoted people's privacy and dignity. One person who used the service said, "We always knock on people's doors before entering." Another staff member said, "We always close doors if we are doing personal care. One person likes to touch their legs and lifts their clothing up. So to allow them to do this we put a blanket over them to preserve their dignity."

Throughout the inspection we observed staff interacting with people in a kind and caring manner. As staff moved around the service they made an effort to stop and talk with people. Staff clearly knew people well, which meant they could have conversations with people that the person enjoyed. We observed one person becoming agitated and was reluctant to leave their chair to go to the dining room, staff spoke gently to this person and prevented them becoming distressed.

At the time of inspection one person living at the service was using an advocate. Advocates help to ensure

that people's views and preferences are heard. Information on how people could access an advocate and what an advocate does was on display in the reception.

At the time of inspection one person had just started to receive palliative care. Palliative care is for people living with a terminal illness. Care records included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These were up to date, the correct form had been used and included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

We saw in the care records that end of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Good

Is the service responsive?

Our findings

Records showed people had their needs assessed before they moved into the service. During this assessment people's communication, cognitive ability, mobility and medical history was assessed. A pre admission draft care plan was made up so information was available to all staff before admission. This ensured the service was able to meet the needs of people they were planning to admit to the service and to meet the needs of a person directly on admission.

Once the person came to live at the service an admission assessment took place. At this assessment the person's weight was taken, their preferred routines were documented and likes and dislikes. We saw evidence of staff supporting people with this. For example, when the tea trolley came round one staff member went to a person's room to collect the person's favourite mug.

Following the admission assessments a full care plan was developed which centred on the person's needs, wishes and preferences. The care plans were detailed with likes and dislikes, how they preferred to sleep for example duvet or blankets. One person liked to get into their pyjamas after tea but did not want to go to bed until around 9pm.

Communication care plans were in place for some people and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with people. We read for one person that they may say no to a cup of tea, when they really mean yes, and that staff may need to repeat the question and monitor the person's body language and facial expressions for clues.

Care plans included information about people's life history such as information on their family and working life. Life history can help people with dementia share their stories and enhance their sense of identity. It is used to help staff understand their past experiences and how they have coped with events in their life. One relative we spoke with said, "I have completed a story board about my relative's life."

Another relative we spoke with said, "Nothings too much trouble. For example a carer brought in some soothing foot cream for my relative. Another brought in some of their favourite jam, they made at home. They have suggested a dementia clock for [relative] and have given me information to read about dementia, very person centred care." Another relative said, "My relative has a specific problem and one carer brought in some headphones to try them with music therapy."

Care plans were reviewed on a regular basis to ensure they accurately reflected people's current support needs. Reviews included the person and family members were invited. One relative said, "I have been offered to review the care plan but I have not got round to this yet."

Daily notes and handovers were used to ensure staff coming onto shift had the latest information on people in order to provide responsive care. These contained a summary of support delivered and any changes to people's preferences or needs observed by staff. Also treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift.

On the day of inspection people were invited to a cookery class. We observed that people were encouraged and supported by the activity co-ordinator and carer's to make biscuits and cakes. People were mixing the cake mixture, using the scales and adding ingredients. The session was well attended with a pleasant atmosphere with staff and people chatting and laughing with each other. People enjoyed reminiscing about how they used to bake at home.

The activity coordinator had also developed a newsletter. The newsletter included historic events that had taken place that month, events and trips that had taken place or were about to take place, dates for the diary of upcoming meetings and shows and a photo gallery of what had taken place in the home.

The service had just employed a new activity co-ordinator who had not started at the time of the inspection. In the meantime care staff were doing activities themselves. We saw a game of skittles taking place on the morning which people were enjoying.

There was an activity notice board displaying what activities were taking place, this included baking, bingo, chair exercises, dog therapy and garden club.

People we spoke with were happy with the activities on offer. Comments included, "I don't do the activities here." Another person said "You always have a good laugh here, you're never bored." A further person commented, "I join in the activities, but I can't remember which ones. I sit in the garden now and again." Other comments included "I like to go out to the bank and the barbers, I helped out at the summer fete, I was on the door." and "I try to take part in activities, the baking, the darts, and every Saturday, bingo. I spend time in the garden if the weathers good. Now and again we get out of the home. Last year we had high tea with the mayor." and "I take part in armchair exercise, I ice cakes, play bingo and darts and I do lots of quizzes." Another person said, "I don't take part in the activities, I walk to church." And another person said, "The activities are quite good, bingo, cake making, puzzles, they are adequate they could do a bit more." One relative said, "My [relative] used to sit in their room all day alone but staff encouraged them to come into the lounge. They now speak to staff and other residents."

Staff we spoke with said there was enough going on for people but would like to take them out more. One staff member said, "There is always something going on but it would be nice if we could plan days out, we don't have a mini bus though." Another staff member said, "The activities have started to improve, residents seem to get something each day. If I could improve something, I would have enough staff on and take people out more."

There was a clear and comprehensive policy in place for managing complaints. This set out what would constitute a complaint, how it would be investigated and the relevant timeframes for doing so. The service had received three complaints so far this year and we could see this had been fully investigated in line with the provider's policy. However, we could not see if people were happy with the outcome of the investigation. The manager agreed to add this to the records.

People and relatives said they know how to raise a concern if needed. People we spoke with said, "The manager is wonderful, very good with us. If you have a problem she'll listen. There's a very good atmosphere here, we all get on well together."

A relative we spoke with said, "I know who to see if I had a complaint, but I've had nothing to complain about." Another relative said, "I would have every confidence things would be resolved if there was a problem."

Requires Improvement

Is the service well-led?

Our findings

The service had a manager in place who had started the process of becoming registered with the Care Quality Commission. The manager started in July 2017.

At our last inspection in October 2016 we found a breach of regulation 17 which relates to good governance. This was due to audits not highlighting the concerns we raised at the time particularly around medicines.

At this inspection we found work was still needed to improved audits. The manager had only been in post about nine weeks and was in the process of working on improving the audits. Audits had not taken place since the previous manager left in April/May 2017 and the audits prior to this could not be found. The new manager had recognised this, with first audits taking place partially in July and then more robustly in August and September.

We saw evidence of audits on care plans, infection control, kitchen records and dining observations. We saw the audits were more of a tick box approach and we could not see evidence of action plans. Medication audits had only started to take place and until August had not highlighted the concerns we found. However, the quality monitoring manager had completed an audit in August and found some of the same concerns we raised, which was topical charts to be implemented, controlled drugs book to be checked and signed weekly, room/fridge temperatures in the medication rooms to be completed, as directed directions to have more information, no gaps to be on MAR charts and medication not to be left on the side in the medication room. This audit did have an action plan in place however did not consistently detail the person responsible for completing the action.

We did see evidence of lessons learnt from some audits such as falls and any weight loss. These lessons were discussed in staff supervision and team meetings.

This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulations) 2014.

People, relatives and staff felt very much supported by the manager. People we spoke with said, "The manager is pretty good." and "The manager is wonderful, very good with us." Relatives we spoke with said, "The manager we have now is very supportive." and "It has got a lot better under this new manager."

Staff we spoke with said, "The current manager is lovely, she has an open door policy." Another staff member said, "We have an absolutely smashing manager. She's more friendly, approachable, helpful, everything you would need from a manager. Morale was low a few months ago, but its back up now." Another staff member said, "I like working here, I like the staff and the atmosphere. I think the current manager has done a lot more than the rest of the managers. I've certainly noticed improvements, for example, staffing levels have gone up. Once over, people had a 'I don't care attitude', but now morale is a lot better." Other comments included, "The new manager is a good asset to the home, she is kind and considerate." and "Very approachable and has good communication skills."

All people we spoke with and staff expressed a wish for stability with management and hoped the new manager would be at the service long term.

Staff we spoke with said there was an open and honest culture with the care home. Staff we spoke with said, "I love working here and the culture is an open and friendly culture."

People who used the service said they were happy living there. Comments included, "It has a homely atmosphere." and "I love living here." and "I am content."

Feedback was sought from people and their relatives through annual questionnaires. The last survey took place in July 2017. The area manager was in the process of collating the answers and arranging and action plan and feedback for people. The majority of the survey was positive, however people commented on the amount of managers that had been in place the last three years and lack of activity coordinator. A new manager had just been appointed and an activity coordinator was currently going through induction.

Meetings took place every month for staff and three times a week flash meetings had just been implemented. Topics discussed at the monthly meetings were staffing, rotas, training, care plans, dining and records. At the flash meetings all the people who used the service were discussed such as any changes in the person's needs, and any concerns. They also discussed maintenance, housekeeping, accidents and incidents and housekeeping. The manager had also implemented a weekend report to capture anything that happened on a weekend so the manager would be aware first thing Monday morning.

Meetings for people who used the service and relatives were to take place quarterly. The last one had taken place in April 2017 where complaints and concerns were discussed, anything new to the home, recruitment and activities. One person who used the service said, "I go to the residents meetings, you can discuss anything." A relative we spoke with said, "I don't attend the residents meetings, but they do listen to people. They decided to swap a lounge and a dining room. When it didn't go down well, they listened and swapped it back again." Another relative said, "I have not had chance to attend the meeting but we could do with getting the feedback from them, such as pinning the notes on the notice board. I have completed a survey."

We asked for a variety of records and documents during our inspection. We found these were well maintained, easily accessible and stored securely. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 The provider did not have systems and processes in place such as regular audits of the service provided to assess, monitor and improve the quality and safety of the service provided.

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 People who used the service were not supported by the proper and safe management of medicines. Regulation 12 (2) (f) (g)

The enforcement action we took:

We have issued a warning notice.