

Runwood Homes Limited

Maun View

Inspection report

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Date of inspection visit:
22 May 2019

Date of publication:
14 June 2019

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

About the service:

We conducted an unannounced inspection at Maun View on 22 May 2019. Maun View is a nursing home and accommodates up to 77 people in one building over two floors, accessed by a passenger lift. On the day of our inspection, 75 people were present at the service. People had either nursing or residential care needs and some people were living with dementia.

People's experience of using this service:

The service met the characteristics of requires improvement in all areas we inspected. We identified three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. These included how medicines were managed, how people's nutritional and hydration needs were met, and the effectiveness of systems and processes that assessed and monitored risks and how records were maintained.

The management of medicines within the nursing unit was not safe or effective. This was in relation to how medicines were ordered, stored, managed and returned to the pharmacy.

Staff levels were found to be insufficient, people had to wait for assistance and staff were task led and did not have time to spend with people. The provider took immediate action and increased staffing levels. Safe staff recruitment procedures were used.

Guidance provided to staff about how to manage known risks to people, either lacked detail or were not available. Staff had received safeguarding training and were aware of their responsibilities to protect people from avoidable harm. However, safeguarding investigations and outcomes were not shared with staff to support learning. There was an analysis of fall incidents to consider themes and patterns. However, the management of falls was not consistent. The risk of the spread of inspection was safely managed.

People's nutrition and hydration support needs were not effectively managed. Information and guidance provided to staff about people's care needs in relation to their health conditions lacked detail or was not available.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. However, there were some inconsistencies in the completion on mental capacity assessments, where people lacked capacity to consent to specific decisions.

The environment was bright and spacious.

Whilst staff overall were kind and caring, they were task led and not always responsive to people's care and support needs.

People were involved with decisions about their care as fully as possible. Advocacy information had been made available. People's records were stored securely to protect their privacy.

People received an assessment before moving to Maun View. Care plans provided staff with information about people's preferences, routines and what was important to them but varied in detail and at times was misleading.

People received opportunities to participate in a variety of social activities, including community visits.

The provider's complaint procedure had been made available for people. Where people were at the end stage of their life, care plans were in place to inform staff of their wishes.

Quality assurance processes were in place; however, these were not always effective in highlighting and addressing the concerns we raised during this inspection. Staff were positive about the new manager who they found to be supportive, approachable and knowledgeable. The manager had a good understanding of the regulatory requirements of their role.

Rating at last inspection:

At the last inspection the service was rated Good (Published 5 March 2018).

Why we inspected:

We carried out this inspection in response to concerns raised by commissioners of this service, who had visited the service and found risks to people's safety.

Follow up:

We will continue to review information we receive about the service until the next scheduled inspection. If we receive any information of concern we may inspect sooner than scheduled.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

Maun View

Detailed findings

Background to this inspection

The inspection:

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

The inspection was prompted in part by information received from the local authority, following their audit visit in May 2019 where risks were identified in relation to people's safety and welfare.

Inspection team: The inspection was carried out by three inspectors, an assistant inspector and 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.

Service and service type:

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

The service did not have a manager registered with the Care Quality Commission, however the manager present on the day of the inspection confirmed they were in the process of submitting their application. The manager had worked at the home since April 2019. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

This comprehensive inspection was unannounced.

What we did:

We reviewed information we had received about the service since the last inspection. This included checking incidents the provider must notify us about. We sought feedback from the local authority and Healthwatch Nottinghamshire.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

During the inspection we spoke with 17 people who used the service and six visiting relatives. We spoke with the manager, operations manager, deputy, the cook, housekeeper, an agency nurse, a nurse, two senior care staff and two care staff and activity coordinator. We reviewed a range of records. This included nine people's care records and medicines records. We also looked at a sample of staff files around their recruitment. Various records in relation to training and supervision of staff, records relating to the management of the home and a variety of operational policies and procedures developed and implemented by the provider.

After the inspection the registered manager sent us further information in relation to, the provider's quality checks and audit process and training records. We have reviewed these as part of the inspection process.

Is the service safe?

Our findings

Safe – This means we looked for evidence that people were safe and protected from avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People's prescribed medicines were not ordered, stored, administered, disposed of and managed consistently. Best practice guidance and the provider's medicine policy and procedure were not followed. This put people at risk of not receiving their prescribed medicines.
- In the nursing unit we found medicine profiles that had the person's photograph, allergies and other important information had not been completed for all people. Staff relied on verbal handover and instruction and this was unsafe practice.
- Medicines prescribed 'as required' such as pain relief, required a protocol to instruct staff of how this should be administered. We found these had not always been completed. This meant people may not have received their medicines when they required.
- Medication administration records (MARs), were not clearly completed and was therefore difficult to ascertain medicines had been administered as prescribed. This included if one person's time critical medicines to ensure maximum symptom control, had been administered on time. Another person required a medicine once a week, but it was not clear if this had been administered. There was no medicine stock control process to monitor medicines.
- One person had a prescribed medicine with no pharmacy label to confirm who the medicine was for and the administration details. This had a hand-written name of another person that had been crossed out.
- One person had a thickening agent prescribed for their drinks. However, the stock of this had been used before a new prescription was ordered.
- The agency nurse told us they had been verbally advised at handover, a person required their medicine covertly. This means the person was unaware they were taking their medicines in a different format, such as in food and drink. However, there was no documentation to support this practice. The person's medicine was given normally, and the person received it with no concerns.
- There were excess of medicines due to them not being returned to the pharmacy in a timely manner. The medicine trolley and clinic room in the nursing unit was generally untidy, with loose medicines found in two people's storage compartment in the medicines trolley. This showed the storage and management of medicines was not organised, effective or safe.

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

- People were confident they received their medicines safely. A person said, "The staff help me take my tablets when I need them."
- Staff responsible for the administration of medicines had completed relevant training and had their

competency assessed.

Assessing risk, safety monitoring and management

Learning lessons when things go wrong

- Risk assessments associated with people's care needs, either lacked guidance or was contradictory. Information was therefore confusing for staff and may have impacted on people receiving safe and effective care.
- One person's moving and handling assessment stated the use of a hoist was variable, with no further guidance. We saw two staff supported this person to transfer without the use of a hoist. Staff told us this was under the instruction of the nurse. It was apparent the person was unable to weight bare. The transfer was therefore unsafe. We discussed this with the manager who agreed to review this person's mobility care plan and risk assessment.
- Personal emergency evacuation plans (PEEP) used to guide staff of people's support needs in the event they needed to evacuate the building were found to be inaccurate. This placed people at risk of receiving inappropriate support. We asked the manager to ensure PEEPs were reviewed immediately to ensure people's safety. This was completed as requested.
- Concerns were identified in the risk management of falls. The provider's slip trips and falls prevention policy and guidance had not been consistently adhered to.
- A person who was admitted to the service in April 2019 pre- assessment, identified they were a known falls risk. Whilst they had a short-term care plan there was no falls risk assessment. This person's care records showed they had a fall in May 2019 where they sustained some minor injuries. Following this fall, a risk assessment was not completed to advise staff of the action required to reduce further risks.
- Another person had experienced a fall on 25 April and 3 May 2019. However, their falls risk assessment updated on 6 May 2019 stated they had experienced one fall.
- There were inconsistencies in the action taken in response to falls. For example, the manager told us after a person had three consecutive falls, a referral to the GP was required for a medicine review and consideration for a referral to the falls team.
- Two people had been reviewed by the GP and their medicines reviewed. One person's falls had reduced following a change in their prescribed medicines. The other person was referred to the community falls team for assessment.
- Two other people who had received more than three falls and had not been referred to the GP or the falls team. They did have sensor equipment in place as a preventative measure to alert staff of when they were independently mobile. Following our inspection, the manager confirmed these people had been referred to the falls team. They also advised, falls management would be discussed at the monthly clinical meeting to improve management and oversight of falls.
- Incidents were recorded on incident records and reviewed by the nurse and manager. A monthly analysis was completed to identify any themes and patterns and if action was required to manage risks more effectively. The analysis considered details such as times and place.

Staffing and recruitment

- Staffing levels were not enough to keep people safe and meet their individual care needs. A repeated concern we received from people, visiting relatives, staff and information received before the inspection was how staffing levels were a concern. A relative said, "There is not enough staff to care for all the residents." A staff member said, "There aren't always enough staff to keep people safe."
- Our observations of staff engagement with people and their response to calls for assistance supported the concerns received. We saw examples where people had to wait a considerable length of time to have their needs met. One person who was cared for in bed was overheard to say to a staff member as they entered their bedroom, they had been waiting for ten minutes for assistance with personal care. We were aware of

another person who required assistance but was unable to use their call bell. We used the call bell to request assistance and the person waited 20 minutes before staff came to them.

- The manager told us they had raised concerns about staffing levels with senior staff and whilst night staffing levels had increased by one care staff, they still had concerns. The regional manager told us there was a dependency assessment tool used to determine staffing levels. They agreed people's needs required a reassessment and assured us this would be a priority to complete. They also agreed to increase staffing levels by two care staff per shift with effect from 23 May 2019. Following our inspection, the manager forwarded us a staff rota to confirm staffing levels had increased as discussed.
- Robust recruitment processes were followed to ensure that people were protected from unsuitable staff. This included carrying out checks on staff's employment history, criminal record and identity. A profile was on file of agency staff to confirm their recruitment checks and training. Checks were completed to ensure nursing staff were registered with the Nursing and Midwifery Council to provide safe practice.

Systems and processes to safeguard people from the risk of abuse

- Where people experienced increased anxiety that affected their mood and behaviour, staff were not provided with guidance of strategies to use to support people. However, some staff told us how they used distraction to reassure people who became anxious.
- Some people told us they did not always feel safe because other people living with dementia came into their rooms. This had resulted in the use of bedroom gates being used for some people to reduce the risk of others entering their bedroom. One person told us they felt safe living at the service. They said, "Definitely feel safe and cared for, it's excellent."
- Staff had received safeguarding training. A safeguarding policy was in place. The provider had the systems in place to ensure the relevant authorities such as the CQC or the local authority safeguarding team, were notified of any allegations of abuse or neglect.
- Staff were aware of the signs of abuse and the action they should take if they identified a concern. They said they would report any concerns to the manager. They were aware of the role of the local authority safeguarding team and staff said they could also go to CQC with safeguarding concerns.

Preventing and controlling infection

- Personal protective equipment (PPE) such as aprons and gloves were readily available, and staff were seen to be using PPE appropriately and there were enough supplies.
- Staff had received infection control training and those spoken with, were aware of the actions needed to prevent the spread of infection. Daily cleaning records and checklists were in place and used consistently, these were monitored by the housekeeping manager.
- The service was found to be generally clean and tidy and housekeeping staff were seen to be present and cleaning the environment.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People's nutrition and hydration needs had not consistently been assessed, sufficiently monitored and reviewed. Weight monitoring and management was found to be a concern impacting on action being taken in a timely manner.
- One person's care record showed their recorded weight in March 2019 was 53.5kg and this reduced to 51.3kg in May 2019. A staff member advised the person had experienced an illness during this time that may have caused some weight loss. However, after the second weight was entered into the electronic care record, it generated a graph to show the weight loss over time. This advised the person required weekly weight monitoring and daily food and fluids to be recorded. Neither of this action had been completed.
- A person who was admitted to the service in April 2019 was known to be nutritionally at risk. However, a malnutrition universal screening tool (MUST) had not been completed. This is a screening for the risk of malnutrition. The person transferred from another care home with their previous weight records. These showed between February 2019 to May 2019 they had lost 6kg. The same person's eating and drinking risk assessment completed on 14 May 2019, stated a referral to the GP or speech and language therapist (SALT) was required. At the time of our inspection this action had not been taken.
- On admission to Maun View this person was prescribed a thickener for drinks. On the day of our inspection, the thickener had been used and a further prescription had to be collected from the pharmacy. The nurse told us they had requested the prescription the day before but there was no record to confirm this. This person's fluid records were unclear suggesting the person may not have had a drink in 16 hours. Staff suggested thickener prescribed for other people may have been used. However, we were unable to confirm this.
- The sharing of people's individual nutritional needs with the cook was not sufficiently robust. This placed people at risk of not receiving meals in a way they preferred or had been assessed as required.
- Information shared with the cook was verbal and a white board in the kitchen recorded specific needs. This only used a person's Christian name and was not dated. One person was recorded twice as requiring a fork mashable meal and also a pureed meal. A person identified as requiring a soft diet had no information in their care records to advise why this was. This meant people may not have had their food provided in a way they required.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Through our observations of people's experience of lunchtime, we saw staff attention and support could have been better. Whilst some people were offered a visual choice of meal from two plated options other

were not. Some people waited up to 40 minutes to receive their meal. We saw some people struggled to eat independently, spilling their food on the floor or eating with their fingers or struggling to use cutlery. Staff supervision and monitoring for people who chose to eat their meal in the lounge was limited. Staff were not consistently responsive to people's support needs.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Where people lacked mental capacity to consent to specific decisions, there was an inconsistent approach in MCA assessments and best interest decisions. Examples of assessments and best interest decisions were seen for care and treatment and medicines. Some people had bedroom door gates in place, this had been in response to relative requests. This was not to restrict the person from leaving but was to prevent other people entering. However, there had been no documented assessment or best interest decisions completed, or a care plan and risk assessment. We discussed this with the manager who agreed this was required and agreed to get these completed as a matter of priority.

- At the time of our inspection no person had any conditions attached to their DoLS authorisation.

- Staff understood the principles of MCA and DoLS. A staff member told us how a person was incorporative with any care interventions and an authorisation was in place to support staff to provide personal care. The staff member said, "[Name] doesn't like any interventions at all, and that affects everything for them. We talk to them and explain what we need to do. We have to do things that are in their best interest sometimes."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider had up to date policies and procedures that reflected national best practice guidance and current legislation to guide staff practice. Recognised assessment tools were used for the care and management of people's needs; such as with skin, falls and nutrition. However, we found policies and procedures, including assessment tools were not consistently used to effectively meet people's needs.

- Assessment of people's care needs included any protected characteristics under the Equality Act 2010 and these were considered in people's care plans. For example, people's needs in relation to their age, gender, religion and disability were identified. Staff recognised, and respected people's diverse needs were important to understand, and these were discussed at the pre- assessment stage. Staff had completed training in equality and diversity.

Staff support: induction, training, skills and experience

- Staff received an induction, ongoing training and opportunities to discuss their work, training and development needs. The provider's training records showed the current training compliance was 86.31 percent and the provider expected percentage was between 90-95 percent. Additional training had been planned for May and June 2019 to ensure staff had received refresher training to update their knowledge.

- Staff were positive about the support they received and told us they received regular opportunities to discuss their work. This included positive comments about the support from the manager. A staff member said, "The manager is doing a great job, his heart is in the right place. The management are approachable, they listen to us, he listens (the manager), he does everything by the book, if you tell him something he acts on it. He's been here a month."

Staff working with other agencies to provide consistent, effective, timely care
Supporting people to live healthier lives, access healthcare services and support

- The manager told us the service participated in the 'red bag scheme.' This is an NHS innovative approach to ensure important information is shared for people between care homes, ambulance staff and hospitals. The red bag contains key information about a person's needs and has effectively proven to improve people's care experience and reduce the length of hospital stays. However, details relating to all people using the service had not been made available.
- There was an inconsistency in the guidance provided to staff about people's health conditions. Examples of information and guidance included the management of diabetes. However, other health conditions such as Parkinsons, staff had no guidance of how this affected the person and the care required to support them. One person's pre-assessment stated they experienced pain in their knees and had arthritis in their feet and back. Staff were not provided with any guidance of the care required including pain assessment and management.

Adapting service, design, decoration to meet people's needs.

- The environment met people's needs. People had personalised their bedrooms to suit their preferences. There was some signage to support people to orientate around the service, but this could be improved upon. The environment was bright and spacious. People had a choice of communal spaces to use, including opportunities to meet with relatives and friends privately and a pleasant outdoor garden they could access and enjoy.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not consistently treated with dignity and respect because staff were not always attentive and responsive to their individual needs. Staff were more task centred than person centred in their delivery of care.
- A high number of people were seen to remain in their bedroom, and many due to living with dementia, could not use the call bell to request assistance. It was unclear if this was people's choice to remain in their bedroom or not. We were not sufficiently assured people who remained in their bedroom were regularly monitored by staff to check their wellbeing.
- We saw staff walk past people's open or closed doors when they were calling out for assistance without always stopping to assist. We also saw people calling for assistance when staff were not around, and we intervened on several occasions and requested staff support. We saw at lunchtime, how a person was trying to eat with the handle of a knife and struggled for ten minutes before a staff member assisted the person to eat. This showed there was a lack of staff organisation and delegation.
- Relatives also raised concerns about the frequency their relation was checked by staff.
- A staff member told us about a person who could isolate themselves from others. They said, "People in their bedrooms do lose out on seeing what is going on, because you (staff) get so wrapped up in what you are doing. I go in each evening to see [name] though. Even just having a ten-minute chat is really good for them."
- Staff told us staffing levels at times meant that people had to wait when they required assistance. Staff said this was a frustration for them. A staff member said, "I do really think that there is a lot of love and care given here. There are a lot of caring staff here."
- Staff spoke about people in a kind and caring manner and had a good understanding of people's routines and preferences. A staff member said, "We (staff) do love the residents, we love to be with them and enjoy each other's company, I wish we could do it more. They eat nice food and we know their needs. We get close to their relatives too. Other than staffing it's a lovely home, we're all really close."

Supporting people to express their views and be involved in making decisions about their care

- People who used the service and their relatives were involved in informal discussions and decisions about their care and treatment. Relatives confirmed they had been involved in their relations pre-assessment. Relatives told us how they spoke with staff about their relations ongoing care and treatment. However, could not recall being invited to participate in a formal review meeting to discuss their relation's needs. A relative said, "I have been involved with care planning for my relation."
- A staff member told us how they encouraged people to be involved in their care. They said, "People are involved sometimes, there is a new person who is involved in creating their care plan from the start. Most people can't do that though, so we usually have to talk to families to find out about their needs."

- We saw some examples where staff encouraged people to make some day to day choices in the way they received their care and people's choices were respected. This included promoting choice in meals and drinks.
- We saw staff used good communication and listening skills when communicating with people, such as gaining people's attention, using clear speech and being patient.
- Independent advocacy information had been made available for people. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. At the time of our inspection no person was using an independent advocate.

Respecting and promoting people's privacy, dignity and independence

- We saw staff knocking on people's bedroom doors and stating who they were before asking to go in rooms. Staff were polite and called people by their chosen name.
- Staff told us how they met people's privacy and dignity needs. A staff member said, "We always knock on bedroom doors, then close the door if doing personal care. I ask people if they mind me helping them. I never do anything without asking."
- The service ensured they maintained their responsibilities in line with the General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. Records were stored safely maintaining the confidentiality of the information recorded.
- There were no restrictions on when people received visitors.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Following an assessment of people's needs, care plans were developed to provide staff with guidance about people's individual diverse needs, preferences and routines. Guidance to staff was not consistently detailed and this impacted on people receiving care that was personalised.
- People's social history, interests, hobbies, pastimes and religious and spiritual preferences were also not consistently recorded. This is important information to support staff in understanding what was important to people.
- A relative told us they had been involved in their relations' pre-assessment and how they had requested an assessment by an external health care professional. The staff member who they had the initial discussion with, no longer worked at the service and they did not know what had happened with their request.
- A relative raised concern about the frequency their relation had been showered and felt this was confusing due to the electronic records staff used to record care provided. Staff confirmed they were having some difficulties using the electronic system and this had contributed to communication difficulties. Further staff training in the use of electronic care records had been booked for June 2019.
- A person who had a pressure ulcer had been assessed by a tissue viability nurse (TVN) who had made recommendations of the type of wound dressing required. The supporting care plan and risk assessment did not record the TVN detailed recommendations. The agency nurse confirmed they had received a verbal handover, and this matched the recommendations made. However, the use on verbal exchange of information was not sufficiently reliable and open to miscommunication.
- A nurse told us they were aware care plans required updating and additional information added, to ensure they reflected people's needs. The nurse told us they had recently become the clinical lead, but had not commenced this role. However, they told us of their plans to update care records was a priority.
- The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard (AIS). The AIS is a law that requires that provisions be made for people with a disability or sensory impairment to have access to the same information about their care as others, but in a way, that they can understand. People's communication needs were identified, recorded and highlighted in care plans. We saw evidence that the identified information and communication needs were met for individuals. Communication care plans provided information for staff on what people's sensory and communication needs were.
- Activity staff developed a weekly activity plan for people to participate in a range of both in house and community activities, external entertainers also visited the service. There was an alternative activity board which included jobs such as pairing socks, laying the tables for lunch folding napkins, sorting laundry, folding sheets and washing pots. An allotment had recently been acquired by the home to allow people to spend time outside and support people who had an interest in gardening. On Thursday's two people were supported to go to the local Methodist church lunch club. Staff explained this also served to promote community links, and how the invite is returned, and the lunch club come to the home on occasions.

- An activity staff member explained how activities were based around people's interests and hobbies. Whilst there was an activity room they told us they also spent time around the home and would visit people in their rooms. All interactions were recorded in individual care plans.
- People told us about the activities they had participated in. A person said, "I enjoy doing the exercises, they have finished now but sessions will be coming again soon."
- On the day of our inspection, a group of people joined in a baking group, we also saw people participating in playing dominoes. Word searches and colouring sheets and pens were also left available for people to use.
- Staff told us how social activities were important for people. A staff member said, "The activities really do happen here, like they are shown on the boards, not just for show. Some people don't like to join in, so they do individual sessions with them as well. Even if it is just talking. A group of them are going to Skegness and stopping overnight again. They did that last year and they all loved it." Another staff member told us how they supported a person to keep in contact with their relatives using skype (communication via the internet). This staff member said, "I try to make people feel special and needed."

Improving care quality in response to complaints or concerns

- The provider's complaint procedure was available for people and visiting relatives. A relation said about complaints or concerns. "When the staff are verbally told that there is a concern, they will respond as soon as able and do things."
- Staff were aware of their responsibility to respond to a complaint. A staff member said, "I would listen to them first, and then get them to make an appointment with the manager. He has done that a few times already. I listen and document what they tell me. But. if it is something I can sort out then I will do straight away, not a problem."
- The provider's compliant log showed action taken in response to complaints and concerns raised and this was in line with the provider's policy and procedure.

End of life care and support

- People who were at the end of their life had plans in place that recorded basic information about their preferences and wishes. Whilst other people did not have end of life care plans. This is important information to ensure staff provide care that meet's people need and wishes.

Is the service well-led?

Our findings

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider's audits and checks had not sufficiently ensured people received consistent safe and effective care, that was based on people's care needs and individual preferences. This placed people at risk of receiving unsafe care.
- The systems and processes in places that monitored the management of medicines in the nursing unit, had not identified the concerns and shortfalls identified during this inspection. The agency nurse had raised concerns about the safety of medicines with the manager the day before our inspection, and some action had been taken but further improvements were required to protect people's safety.
- There were no processes in place to check MCA assessments and best interest decisions had been completed where restrictions had been put in place.
- Action required to assess, monitor and mitigate risks had not been consistently completed and reviewed to protect people from harm. PEEPs were not accurate or reflective of people's needs. People's risk assessments either lacked details or had not been completed.
- Records of people's care and treatment had not been kept up to date or correctly reflected their care needs, wishes and preferences. The systems in place for staff to exchange information about people's care and treatment needs were not sufficiently robust. There was over use of verbal exchanges of information that was open to interpretation and confusion, placing people at increased risk of not having their care needs met.
- People's dependency needs had not been consistently assessed to ensure staffing levels were sufficient in meeting people's safety and care needs.
- By speaking with staff, it was evident that safeguarding referrals and investigation outcomes had not been shared with staff. For example, a staff member said, "Safeguarding - we've not had any safeguarding issues, an issue would be financial, emotional abuse, any form of abuse, we safeguard to protect them, report it straight away to manager or police." Within the last 12 months safeguarding incidents had been reported to the local authority safeguarding for investigation, and at the time of our inspection there were current safeguarding investigations taking place.
- The audits and checks that monitored the safety of the premises and environment were found to have some shortfalls. For example, not all hot water temperature outlets were monitored to ensure temperatures were within safe limits. The linen storage cupboard was found to have clean blankets stored on the floor. Audits and checks completed by the maintenance person had not been signed by the manager as part of the provider's governance procedures.

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

- The manager was new to the service and had started to identify areas for improvement. They had developed an action plan that showed actions required, by whom with a target date for completion. The provider's senior manager who had responsibility and oversight of the service, also completed audits and checks and areas identified for action were added to the action plan.
- The manager was an experienced registered manager who demonstrated a good awareness and understanding of their role and responsibilities.
- It is a legal requirement that a provider's latest CQC inspection is displayed at the home where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the home.
- The provider and registered manager are required to notify CQC of reportable incidents as part of their registration regulatory requirements. This is to enable CQC to effectively monitor services. Statutory notifications had been submitted to notify of reportable incidents. However, we identified from incident records where these had not always been reported. We discussed this with the management team. We were satisfied this was an oversight and the manager assured us lessons had been learnt and would ensure all reportable incidents were reported in the future.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- People and relatives, we spoke with told us their main concerns were about staffing levels and communication.
- The staff team were positive with the appointment of the new manager and told us that although they had only been in post a few weeks they appeared approachable, and they were happy to speak with them should they have any concerns. A staff member said, "The manager is polite to everyone and sends a memo to us about things that need addressing. He gives us a timescale to get things done."
- Staff received opportunities to be involved in the development of the service. Staff meetings were arranged regularly. A staff member said, "The staff meetings are where we get allocated things we need to do and then we all feel part of things more." The manager told us of their commitment to improve communication systems and monthly clinical governance meetings had been developed.
- We saw the manager's interaction with staff, people who used the service and relatives. They had a calm and approachable manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The manager told us whilst meetings had been arranged for people and relatives to meet with staff to discuss their experience about the service and to share information, these meetings had not been supported. However, the manager told us they had a commitment to look at ways of encouraging people to participate in the near future.
- The provider invited people on an annual basis to complete a satisfaction survey. Whilst we saw information relating to feedback received during 2018, the feedback was not specific to Maun View but all the provider's services. We were therefore unable to make a judgement about people's feedback regarding the service provided by Maun View.

Continuous learning and improving care

- The management team used the analysis of incidents to consider lessons learnt and internal systems and processes that monitored quality and safety to make improvements.
- The manager attended internal meetings with other managers and senior leaders to share information and learning.

Working in partnership with others

- Staff worked with external healthcare professionals to support people in meeting their individual needs and achieve good outcomes.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's prescribed medicines were not managed effectively or safely. Policies and procedures were not followed. 12 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs. People's needs associated with their nutrition and hydration had not been sufficiently assessed and support provided. 14 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and mitigate risks were not fully or consistently effective.

Records relating to the care and treatment of people were not sufficiently accurate, detailed or kept up to date.

17 (1)