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Tremethick 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 11 April 2017. The last comprehensive inspection took place in March 2016 where we found a breach of the regulations regarding the quality of the records kept at the service. Whilst the service had met the requirements of the regulations at an unannounced focused inspection in September 2016, the service rating remained Requires Improvement as we required evidence of sustained good practice over time. Prior to this inspection the service had reported to CQC that two medicine errors had occurred and a quantity of medicines could not be found. The service involved external agencies to help them carry out an investigation in to this concern.

Tremethick House is a care home which offers care and support for up to 42 predominantly older people. At the time of the inspection there were 37 people living at the service. Some of these people were living with dementia.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was on extended absence at the time of this inspection. There was an acting manager in post supported by the senior management team.

The service used an electronic medicines management system. The management of medicines was not robust. There were suitable arrangements for storing medicines which required extra security. However the records were not always accurate. For example, quantities of liquids were incorrect. One medicine had been disposed of but it was still recorded as in stock in the record book. There were no records for another medicine which legally must be recorded. Weekly checks had been made for these medicines but they had not identified these issues. There were no policies or procedures available for staff to follow for this type of medicine.

An error was found in the recording of one person's medicines following transfer from the hospital to Tremethick House. Not all staff who administered medicines were fully trained in the use of the electronic medicine system used at the service. Regular effective audits were not taking place and any errors were not being identified in a timely manner.

Care plans were not always effectively reviewed to take account of any changes that may have taken place in a person's needs. Risk assessments were not always completed when a risk had been identified. This meant there was a lack of information for staff on the action to take to help reduce an identified risk. Some people had been assessed as requiring regular monitoring and re-positioning whilst in bed in order to help prevent pressure damage to their skin. This action was not always recorded as having been followed by staff. Pressure relieving mattresses were regularly audited. However, we found the audit carried out on the day of this inspection was not effective. Mattresses were not always correctly set according to the weight of

the person.

Accidents and incidents that occurred at the service were recorded and audited. However, action taken to help reduce the risk of reoccurrence was not evidenced. This meant incidents re-occurred.

At the last inspection the service was not publicly displaying the recent report and rating provided by CQC. At this inspection the service did not display the recent report and rating as they are required to do.

We walked around the service which was comfortable and bedrooms were personalised to reflect people's individual tastes. People were treated with kindness. There were positive interactions between people and staff. People told us they were happy living at the service. A recent quality assurance survey sought the views of people living at the service and their families. Responses to this survey were largely positive. Action had been taken to respond to some comments made. This meant the service was listening to people's views.

Staff were recruited safely and were supported by a system of induction, supervision and training. Staff were not receiving annual appraisals. People were supported by staff who knew how to recognise abuse and how to respond to concerns. Staff received training relevant for their role and there were opportunities for on-going training and support and development. Staff meetings were held regularly and provided an opportunity for staff to air any concerns or suggestions they had regarding the running of the service and share information.

The service had identified the minimum numbers of staff required to meet people's needs. The service had one vacancy at the time of this inspection which was being covered by an agency care worker. However, people, relatives and external healthcare professionals commented that there were times when staff were 'hard to find' and people reported having to wait for attention. Bells were heard ringing throughout the inspection by people requesting assistance. The call bell response times were audited showing an average response time of approximately 5 minutes.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. The service held an appropriate policy for the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. Appropriate applications had been made for authorisations for potentially restrictive care plans. However, the records of one person's DoLS status were out of date and inaccurate. A care plan review had not identified this.

Tremethick House used an external meal provider who delivered a variety of frozen meals to the service. People were provided with a choice of meals according to their dietary requirements and preferences. Where necessary staff monitored what people ate to help ensure they stayed healthy. However, these records were not always completed by staff at each meal. People's weight was monitored and recorded. However, the action taken to address the risk and direct staff on how to reduce the risk of further weight loss was not always evidenced. The service had received a three star rating from an inspection of the Food Standards agency. Actions required from this inspection were in the process of being addressed by the provider such as new flooring and kitchen units.

The premises were regularly checked for any defects. The building was warm and mostly clean. Some carpets in the service were soiled and remained so until mid afternoon on the day of the inspection. There were areas of the service that required repair such as damaged doors and corridors from the passage of wheelchairs and moving and handling equipment. People's bedroom doors were numbered with no other identifying signage. The service did not have any specific pictorial signage to help meet the needs of people living with dementia to orientate them to areas of the building such as bathrooms etc., Equipment such as

passenger lift and moving and handling equipment was regularly serviced to ensure it was safe to use.

People had access to a variety of activities. Two activity co ordinators were in post who arranged regular events for people. These included, trips out in the minibus, seasonal events such as at Christmas and on St Patricks day along with visiting entertainers and children, craft and games.

The registered manager was on extended absence at the time of this inspection and the acting manager was supported by the senior management team of Anson Care as well as a team of senior carers, carers and ancillary staff. Staff told us they felt morale was good and that they could access any support they may need.

There were breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of this 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 entirely safe. The review and management of identified risks was not effective.

Systems for the management of medicines were not robust

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service.

Is the service effective?

Good

The service was effective. Staff were provided with training and supported by the management team.

People had access to a varied and nutritious diet.

The management had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected.

Is the service caring?

Good

The service was caring. People who used the service, relatives and healthcare professionals were positive about the service and the way staff treated the people they supported.

Staff were kind and compassionate and treated people well. Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Requires Improvement

The service was not entirely responsive. Care plan guidance was not always followed by staff and reviews did not always take account of any changes in people's needs.

People were able to make choices and have control over the care

and support they received.

People were consulted and involved in the running of the service, their views were sought and acted upon.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. Concerns identified by a recent independent audit together with this and previous inspections had not been acted upon.

There were clear lines of responsibility and accountatability at the service.

Staff were supported by the management team.

Tremethick 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 checked 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.

The inspection took place on 11 April 2017. The inspection was carried out by two adult social care inspectors and a pharmacy specialist.

Before the inspection we reviewed information we held on the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the service. Not everyone we met who was living at Tremethick House was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices. We spoke with eight staff plus the acting manager, provider and operational managers. We spoke with two visitors and two healthcare professionals. Following the inspection we spoke with one further healthcare professional and two families of people living at the service.

We looked at care documentation for five people living at Tremethick House, medicines records for 9 people, three staff files, training records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection the service contacted CQC to report medicine errors. One in January 2017 when a person was given the wrong medicine and two further incidents in February 2017. In one instance prescribed medicines for one person ran out and were not available for use. The person subsequently had a seizure which was, at least partly, contributable to them not receiving their medicines as prescribed. A second person did not have their medicine dose altered correctly following the result of a blood test result being phoned through to the service from the GP surgery. This led to them having the wrong dose until a subsequent blood test result was received and the error noticed. The service also reported they had 'lost a concerning amount' of two specific medicines between February and March 2017. External agencies were contacted by the service to support an investigation. The investigation identified that pharmacy deliveries were not being checked before being entered on to the electronic medicines management system used at Tremethick House. An assumption was made by staff that the ordered amount had been delivered when in fact it had not. This led to inaccurate amounts of medicines being recorded as held at the service. The service had taken some action to address this concern and were now checking every pack delivered for the specific numbers of tablets before recording them on the system. However, this practice had not been in place for long enough to assure us it was well embedded and effective. We concluded the systems for the management and administration of medicines were not robust.

This contributed to a breach of Regulation 12 of the Health and Social Act (Regulated Actiivities) 2014.

At this inspection we looked at the systems in place for managing medicines. We spoke to staff involved in the governance and administration of medicines, observed medicine administration for four people and examined nine medicines administration records (MARs). Staff managed medicines in a way that did not always keep people safe.

Medicines were given by care staff who had received training, and had signed that they read and understood the medicine policy. Although staff had received training in respect of the administration of medicines this had not been followed up by competency assessments to establish they were able to administer medicines safely.

There were suitable arrangements for storing medicines which required extra security. However the records were not always accurate. For example, the records for quantities of liquid medicines were incorrect. One medicine had been disposed of but it was still recorded as in stock in the record book. There were no records for another medicine which legally must be recorded. Weekly checks had been made for these medicines but they had not identified these issues. There were no policies or procedures available for staff to follow when administering this type of medicine.

Robust medicine audits were not completed by the manager. The service was aware of this and were planning training on how to audit medicines using the electronic system. There was a system for reporting any medicines errors and incidents. These were investigated so that measures could be put in place to

prevent them from happening again. Three incidents which had occurred during February and March 2017 had been investigated and we saw the plans that had been drawn up to address these. However some of these actions had been started but were not complete at the time of this inspection.

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

The service used an electronic system for the administration of medicines. We checked nine people's medicines administration records (MAR charts). The records were completed using the electronic system whenever medicines were administered, including the application of creams and other external preparations. If medicines were not given the reason was recorded and if medicines were refused this was reported to the senior member of staff on duty.

One person had been discharged from hospital to the service. The information sent from the hospital was incomplete. Care home staff had requested further information from the hospital, but documents for a 'when required' medicine showed two different doses. Staff had not clearly identified what information was missing and taken action to help ensure people received their medicine as prescribed.

Medicines were stored securely in a locked room and in medicine trolleys. The room temperature was not monitored to make sure medicines were stored at the correct temperatures so that they would be safe and effective. Other medicines were stored in a dedicated locked refrigerator, the temperature of this was checked daily and action taken if it was outside the required temperature range.

The service used an electronic records management system on to which staff and management entered all the information relating to the care and support of each person living at the service. Accidents and incidents that took place in the service were recorded by staff and passed to management for auditing. However, once audited and clear reports created, there was no evidence of specific action taken to address any patterns or trends. This meant that incidents continued to occur. For example, one person had fallen 12 times in January 2017 the reports stated the falls always occurred in the person's bedroom. A falls risk assessment dated 3 February 2017 had not been reviewed or changed and stated the person was at a low risk of falls. This risk assessment, stated that the last fall was on 9 January 2017. That specific event had not been recorded on the falls audit. Incident records showed a further ten recorded falls in January after the 9 January 2017. A moving and handling risk assessment reviewed on 5 March 2017 stated the person was, "Fully mobile without aids" and "Actively co-operated in moving and handling." There was no mention of the many falls that had taken place and no new guidance or direction for staff on how to support this person and help reduce the risk of further falls. A further five falls took place in February 2017. This person's care plan had been reviewed on 8 April 2017 and had not taken account of the number of falls that had taken place. This meant staff were not provided with guidance on how to help ensure the risk for further falls was reduced.

During the inspection the person was heard frequently calling for assistance. Staff confirmed the person was often vocal during the day and it was not unusual to hear them shouting. The person's room was at the end of a corridor and staff did not pass it to go to any other part of the building. The person's care plan did not make any reference to staff regularly checking this person to help ensure they were well and comfortable. An inspector went to visit the person during the afternoon of this inspection. As they approached they could clearly hear the person calling out. They found the person had fallen to the floor from their chair. This demonstrated the systems in place to ensure the person's safety and comfort were ineffective. The care plan stated a referral had been made to the physiotherapist and to the falls clinic. It was not clear if advice had been received as a result of these referrals. This meant that action taken had not been

effective in helping to reduce the risk of further falls.

At our last inspection in September 2016 we identified that risk assessments were not always reviewed regularly. We were assured that once the new electronic records system was in use the system would be set up to ensure that risk assessments were all updated when each care plan was reviewed.

At this inspection we found care plans contained risk assessments for a range of issues such as moving and handling, falls and people's nutritional risks. The front screen of the electronic records system, which held people's care plans, highlighted two people who had lost weight. One person had lost 14 kgs between 5 March 2017 and 22 March 2017 due to having been very unwell. Specialist medical treatment had been provided for this person and staff stated they were much better and now spending time out of bed. This person's nutritional risk assessment had not been updated since January 2017 to take account of the weight loss. This meant staff were not provided with any guidance on how to help reduce the risk of further weight loss. The second person highlighted as having lost weight had also not had any review of their needs and risks since this had been identified. Specialist health treatment had been provided and staff were now recording the person's food and fluid intake. However, there was no record of any action taken to help reduce further weight loss or any change in the guidance provided to staff on how to meet their current needs.

This meant that the service was not effectively updating risk assessments when changes in people's needs occurred. The electronic records system was not prompting this at care plan reviews as we were assured it would at our previous inspection.

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

People and their families told us they felt it's was safe at Tremethick House. Comments included; "I am happy here the staff are all lovely" and "I feel (the person) is quite safe there."

Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. They were aware of the whistleblowing and safeguarding policies and procedures. Most staff had received recent training updates on Safeguarding Adults and were aware of how to contact the local authority, the lead organisation for investigating safeguarding concerns in the county.

The service held the personal money for people who lived at the service. People were able to easily access this money to use for hairdressing, toiletries and items they may wish to purchase. Financial records were overseen by the manager. We checked the money held for two people against the records kept at the service and both tallied.

Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately to reduce cross infection risks. All bathrooms and toilets had soap and paper towels available for use.

The service was well maintained and all necessary safety checks and tests had been completed by appropriately skilled contractors. Fire safety drills had been regularly completed and all firefighting equipment had been regularly serviced. Each person had information held at the service which identified the action to be taken for each person in the event of an emergency evacuation of the premises.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of two

references.

The service had identified the number of staff needed to meet people's needs. There was one agency staff member present on the day of this inspection. There were covering a vacant post which had been recently filled. The new member of staff was due to start work in the next few weeks. The staff team had an appropriate mix of skills and experience to meet people's needs. We heard bells ringing during the inspection and staff were seen to be very busy. People, relatives and external healthcare professionals commented that there were times when staff were 'hard to find' and people reported having to wait for attention. Bells were heard ringing throughout the inspection by people requesting assistance. The call bell response times were audited showing an average response time of approximately 5 minutes. On the day of this inspection there were six care staff on shift supported by a senior carer and a manager. There were two staff who worked at night. Shifts were varied with staff starting at 8am and some changing shift at lunchtime and some working a long day till 9pm. Staff had requested additional staff to be present at specific times of the day to help with workload pressures and management had responded to this by adding a new shift from 6pm to 10.30pm. Staff reported feeling improved morale recently and most stated they worked well together.

Good

Is the service effective?

Our findings

People living at the service were not always able to communicate their views and experiences to us due to their healthcare needs. We observed care provision to help us understand the experiences of people who used the service.

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. There was little reference to people's capacity on the electronic records system. We did not see any evidence that people had agreed to their care provision or care plans.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had made appropriate applications for a number of people to have authorisation for potentially restrictive care plans. One person had been assessed by the local DoLS team and issued with an authorisation. This was recorded in their care plan. However, the authorisation had expired in November 2016 and not been reviewed. The acting manger told us this was because the person no longer required that restriction. This demonstrated the service understood the principles of the MCA and DoLS and was protecting the person's rights. However, the DoLS status for this person had not been effectively updated at their last care plan review and the care plan continued to state that the person had a DoLS in place. This meant staff were not provided with accurate and current information. This was amended once the inspector had raised the issue with the management team during the inspection.

At our last inspection the DoLS policy was in need of updating to reflect changes in the legislation. This had been carried out and the service now held an appropriate policy to inform staff. Some staff had received training on this legislation and were aware of how to protect people's rights.

People told us they were happy living at the service and being cared for by kind staff. Families told us they felt the service cared for their family member effectively and met their needs.

We looked around the premises. There was some damage to doors and doorways from wheelchairs and hoists. Some carpets were found to be soiled during the morning of the inspection and remained this way till the middle of the afternoon when domestic staff cleaned them. There were no unpleasant odours within the service at the time of this inspection. There were people living at the service who had dementia but there was little pictorial signage provided to aid their orientation to different parts of the building such as the bathroom or their own bedroom. Doors were marked with numbers only.

Staff demonstrated a good knowledge of people's needs and told us how they cared for each individual to

ensure they received effective care and support. Staff told us they received training. This was a mixture of face to face training, e-learning and paper based courses. Training records showed most staff were provided with updates. Some staff were overdue for refresher training and training sessions had been recently arranged by the management team.

Staff received regular supervision and support from the management team. They told us they felt well supported by the registered manager and were able to ask for additional support if they needed it. Not all staff had been offered an annual appraisal.

Newly employed staff were required to complete an induction before starting work.This included training identified as necessary for the service and familiarisation with the service and the organisation's policies and procedures. The induction was in line with the Care Certificate. Ths is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. Staff told us they had completed or were working towards completing the care certificate and had shadowed other workers before they started to work on their own.

Tremethick House had all main meals pre-prepared and delivered by an external company. These were delivered frozen. There was a menu displayed in the dining room and people confirmed they had a choice of meals. Food was provided according to people's needs with pureed meals presented as individual food items of different colours on a plate helping to encourage a person to eat. People told us they enjoyed the food. A recent survey had received positive responses with some specific items being requested by people living at the service. Some of these requests had been responded to with homemade chips now being provided with some meals and wine with Sunday lunch.

We spoke with the cook who was knowledgeable about people's individual needs and likes and dislikes. They met new residents in order to identify their dietary requirements and preferences. Where possible they tried to cater for individuals' specific preferences. They told us they would always substitute a previously chosen meal for something else if people asked.

People's weight was monitored and recorded. Food and fluid charts were kept when this had been deemed necessary for people's well-being. For example, when people had lost weight. Staff were directed to record all food and drinks taken by a person on to the computer. However, there were some gaps in this information where staff had not always recorded meals. The service had received a three star rating from an inspection by the Food Standards agency. Actions required from this inspection were in the process of being addressed by the provider such as new flooring and kitchen units.

People had access to healthcare professionals including GP's, opticians and chiropodists. Care records contained details of any multi-disciplinary notes. Some people had the district nurses visiting them regularly to attend to their nursing needs such as dressings and injections. The nurses recorded their visits in a diary as they did not have access to the computerised record system used at the service

Good

Is the service caring?

Our findings

People and their relatives told us they found the staff to be caring and kind. Healthcare professionals were positive about the staff interactions with people. Comments included, "If you want anything done they will do it" and "Staff are marvellous." During the inspection we heard staff talking to people while they supported them to eat a meal. One staff member who was supporting a person with their meal while they were in bed was heard to say, "You are lovely and warm in there aren't you, are you enjoying your meal?" The radio was playing a song and they said, "Do you remember this song?"

We spent time in the communal areas of the service during our inspection. Most people were comfortable in their surroundings with no signs of agitation or stress. Staff were kind, respectful and spoke with people considerately. We saw relationships between people were relaxed and friendly. People's dignity and privacy was respected. For example staff closed doors when providing personal care. One person was heard calling from their room throughout the inspection.

Some people's life histories were documented in their care plans. This is important as it helps care staff gain an understanding of what has made the person who they are today. Staff were able to tell us about people's backgrounds and past lives.

People's bedrooms were decorated and furnished to reflect their personal tastes. People were encouraged to have personal possessions around them that helped give their room a familiar feel.

Visitors told us they visited regularly at different times and were always greeted by staff who were able to speak with them about their family member knowledgeably. People were well dressed in clean clothes. The laundry was well organised and systems had been put in place to help ensure people had their clothes returned to them.

People and their families were involved in decisions about the running of the service as well as their care. However, the version of the electronic care plan system in use at the time of this inspection was not able to record a person's signature, to show they were in agreement with the contents. Paper copies of the care plans were not routinely printed off for people to see. This meant there was no evidence that people had seen or were aware of their own care plans and were involved in the reviews.

The service had held residents meetings. This gave people the opportunity to share views and experiences of the service provided. We saw the minutes of such meetings where people suggested changes to food and drinks provided. The management team had listened to people's views and their comments had been passed to the hotel services manager for consideration.

During the inspection staff were seen providing care and support in a caring manner. Interactions between staff and people at the service were caring with conversations being held in gentle and understanding way. Staff were clear about people's individual preferences regarding how they wished their care to be provided.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we identified that guidance in people's care plans was not always followed by care staff. For example, regular re-positioning was required every two hours for some people who were cared for in bed. Staff did not always record this leading to gaps in the records where there was no record of the person being re-positioned. However, we were able to establish at the last inspection that there had been no impact on the person's well-being at that time.

At this inspection visiting healthcare professionals told us that they sometimes found it difficult to find a member of staff when they visited. Comments included, "It is always quite busy when we come here" and "Staff are always willing to help but clearly busy." Visiting healthcare professionals did have some concerns about the increase in the number of people who required pressure area care at the service. There were several people who required nursing support who were living at the service at the time of this inspection. The tissue viability nurse visited the service during this inspection and reported that one person's pressure sore had shown, "Some deterioration" and they required increased re-positioning. They suggested staff move this person every two hours. The care plan stated that this person had required re-positioning every four hours up until the district nurses visit on the 7 April 2017. However, there were gaps of up to eight hours in this person's re-positioning records since that advice was given. This meant staff were not following the guidance in the care plan and the person had experienced some deterioration in their skin condition.

Another person's care plan stated on 23 March 2017 "Small pressure area, 2 hourly turns and skin bundles." There were no skin bundle records for this person. A skin bundle is a visual assessment carried out by staff of the person's whole body checking for any pink, red or broken skin which are then recorded. It is designed to highlight any changes in a person's skin condition in a timely manner. Staff confirmed they were not completing this assessment of the person's skin. This person's risk assessment had not been updated since January 2017. This person spent some time in the middle of the day out of bed in a chair. However, when in bed re-positioning records also showed gaps of up to six hours where staff had not recorded re-positioning. This meant staff were not following the guidance in the care plan.

On the day of the inspection visit staff were carrying out a pressure relieving mattress audit. We checked the settings of two people's mattresses against their weights to see if the mattress was set correctly. One person had a recorded weight of 44 Kgs and their mattress was set for a person of 70 Kgs. Another person had their mattress recorded as correctly set when there was no weight recorded for the person on the audit for it to be checked against. This mattress was set for a person weighing 40 kgs when their care plan stated they weighed 55 kgs. Both mattresses were recorded on the audit as set correctly. This meant the audit was ineffective.

Care plans were regularly reviewed. However, changes that had taken place in a person's support needs were not effectively reviewed and information was not updated to provide accurate guidance and direction for staff. For example, DoLS status, falls risk, and weight loss. This meant that staff were not provided with information and guidance on how to support a person well.

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

Relatives reported that staff responded well to people's requests for assistance. One commented, "Mum has never reported any concerns or issues to us about the staff."

Visitors were made welcome and were able to visit at any time. Staff were seen greeting visitors throughout the inspection and chatting knowledgeably to them about their family member. One visitor told us that they found the staff to be responsive and caring.

Daily progress notes were consistently completed by staff on the electronic record and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being.

People had access to a range of activities both within the service and outside. Two activities co-ordinators were employed. There was an organised programme of events including regular trips out and visits from entertainers and young people. We were told about events which had taken place at Christmas and on St Patricks Day. People were taken out in the minibus to visit the local area and there was some Easter events planned for people to enjoy.

Some people chose not to take part in organised activities and therefore were at risk of becoming isolated. During the inspection we saw some people either chose to remain in their rooms or were confined to bed because of their health needs. Activities were planned for people to have on a one to one basis where possible.

People who lived at the service were involved in the running of the service. A recent quality assurance survey had sought the views of people living at the service. The responses were largely positive and some people had made specific requests.

People and families were provided with information on how to raise any concerns they may have. Details of the complaints procedure were available at the service. People told us they had not had any reason to complain. The service received many compliments. Comments included, "Really pleased with the care and support" and "Welcoming and friendly."

Requires Improvement

Is the service well-led?

Our findings

At our last two comprehensive inspections in April 2015 and March 2016 we found breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We had concerns about the quality and monitoring of records held at the service such as re-positioning records, care plans not always being accurate and the management of weight loss. At the focused inspection in September 2016 we found risk assessments were not always reviewed regularly, re-positioning was not always carried out according to the care plan guidance and the service was not displaying the latest CQC report and rating as required.

The service had commissioned an independent quality audit in January 2017. This report highlighted what was working well and what area needed some improvement. This report had highlighted concerns with medicines management, care plan detail, recording of care and action taken following accident and incidents. The audit stated that care plans did not always accurately reflect the support needed or delivered to people. It also stated that direction in care plans was not always followed by staff. We found at this inspection that such concerns have continued to occur and this has been detailed in the Responsive section of this report.

The audit stated that the manager should document any action taken following accidents or incidents and keep an audit trail of action taken. This had not been carried out and the management of accidents and incidents was a concern at this inspection and is detailed in the Safe domain of this report.

Gaps were identified by this audit in people's 'turn and welfare' checks, which record the re-positioning of people cared for in bed by staff. At our inspection we found this issue continued to be of concern. This meant that effective action had not been taken by the service following the independent audit report in January 2017.

Care plans were reviewed regularly but not effectively. For example, one person's DoLS authorisation had expired in November 2016. This care plan had been reviewed since this had taken place, however, the care plan continued to show this person had a valid DoLS authorisation in place. This meant that care plan reviews were not effective.

At the last inspection we were told that a key worker system would be implemented. At this inspection this system was not impacting on the close review of people and their changing needs and the information held on their care plan.

The service has a responsibility to display the latest CQC report and ratings. At the last inspection this was not displayed. At this inspection this continued to be a concern as the latest report and rating was not displayed for the public. The service had sent CQC notifications of significant events that took place at the service such as deaths and DoLS authorisations granted.
Following our inspection in May 2016 the provider sent us an action plan which stated that a key worker system would be in place by the end of June 2016. This is where individual members of staff take on a leadership role for ensuring a person's care plan is up to date, act as their advocate within the service and

communicate with health professionals and relatives. However, this system had not been fully implemented at the time of this inspection. We were told key workers were responsible for buying Christmas and birthday presents for a person whom they knew well but did not take part in their care plan review or care management. Some care plans were found to hold inaccurate out of date information. This demonstrated the systems for ensuring named staff had clear oversight of people's care planning had not been effectively applied.

At the last inspection we were given assurances by the registered manager that the new electronic system for recording care provided would be set up to prompt staff to review risk assessments when updating care plans. At this inspection we found this was not the case as risk assessments were not updated and accurate despite reviews having taken place.

Concerns identified at this inspection had not been identified by the management of the service prior to this inspection and audits carried out on pressure relieving mattresses and medicines were not effective.

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

Relatives and staff told us the acting manager was approachable and friendly. Staff were positive about the support and guidance provided by the acting manager. The acting manager was being well supported by the operations managers and the provider. There were clear lines of accountability and responsibility both within the service and at provider level. The acting manager was supported by a team of senior care staff, carers and ancillary staff who all felt part of a team and that morale had improved throughout the service. There was some concern and comment from staff about some staff 'not always pulling their weight'. We discussed this with the provider who had already been made aware of this issue and it was being addressed through supervision.

Staff told us they felt well supported through supervision and regular staff meetings. Staff commented, "I love it here" and "I feel well supported and can go to them (managers) with anything at all."

There were systems in place to support all staff. Staff meetings took place regularly. These were an opportunity to keep staff informed of any operational changes. The meetings also gave an opportunity for staff to voice their opinions or concerns regarding any changes. Senior care workers and catering staff also had separate team meetings.

The acting manager worked in the service regularly providing care and supporting staff. This meant they were aware of the culture of the service at all times. Daily staff handovers provided each shift with a picture of each person at the service and encouraged two way communication between care staff and the registered manager. This did not always ensure that everyone who worked with people who lived at the service were aware of the needs of each individual. For example, one person's care plan stated they should have their skin monitored daily and this was not being done by staff who were unaware of the need to record skin bundles for a person.

There was a maintenance person in post with responsibility for the maintenance and auditing of the premises. Any defects reported were addressed in a timely manner. The providers carried out regular repairs and maintenance work to the premises. The boiler, electrics and water supply had been tested to ensure they were safe to use. There were records that showed manual handling equipment had been serviced. Fire alarms and evacuation procedures were checked by staff, the fire authority and external contractors, to ensure they worked. There was a record of regular fire drills.

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 Care and treatment must be provided in a safe way for service users. The registered person must assess the risks to the health and safety of service users of receiving the care of treatment and do all that is reasonably practicable to mitigate any such risks. Medicines must be managed safely.

The enforcement action we took:

Warning notice issued Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirement of the regulations. The registered person must evaluate and improve their practice in respect of assessing, monitoring and mitigating the risks to people using the service and act on feedback from relevant persons on the service provided in the carrying on of the regulated activity.

The enforcement action we took:

warning notice issued Regulation 17 (1) (2) (f)