Valley View Care Home Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 December 2017. The inspection was unannounced.

Valley View Care Home Limited is registered to provide accommodation and personal care with nursing for up to 33 people. There were 30 people living at the service at the time of our inspection.

People living in the service required registered nurses and care staff to provide their nursing care and support needs. Some people were living with dementia and some people had medical conditions such as diabetes or respiratory conditions and some people were recovering from suffering a stroke. Most people living in the service needed some support to move around. Some required the support of one staff member to move around whilst others required the support of two staff. Some people needed staff to support them to move by using a hoist. Some people were unwell and nursed in bed and others chose to be cared for in bed.

The service was set out over two floors with a passenger lift to take people between floors. A large communal lounge was available for people to sit together if they wished and a spacious dining area where people could eat their meals if they chose to. A small conservatory was also accessible for people.

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

The provider had previously been registered with the Care Quality Commission (CQC) at this location. However, they had changed the legal entity of this service and this required them to apply for a new registration with CQC, which commenced on 23 December 2016. The service had continued within the same premises and with the same staff team and registered manager. This was the first inspection under the new registration. However, you can find previous inspection reports on the CQC website.

We found there were areas of the care and support at the service that required improvements to be made.

Some elements of how the administration of people's medicines was managed needed improvement. Prescribed thickeners to add to people's drinks to prevent choking were not stored or administered safely. Medicines audits did not highlight concerns found.

Individual risks had not always been fully assessed with the steps and guidance required to keep people safe. Accidents and incidents were not always recorded appropriately by following the processes in place. There were areas of concern regarding security within the premises to ensure people remained safe.

Nurses and staff did not always have the training required to carry out their role. Many staff had not completed the mandatory training required. Some important training had not been undertaken by nurses and staff. Staff had not always had the opportunity to take part in regular supervision sessions to aid their personal development.

People had not been supported appropriately to make decisions and choices when they may lack the capacity to do so. Any decisions made had not been made in their best interests.

Nurses and staff did not keep consistent records of people's care. Daily recording charts were not always completed. Care plans were in place but not always up to date or consistently capturing people's individual care and support needs or preferences.

The provider had monitoring and auditing processes in place to check the quality and safety of the nursing care provided. However, these audits were not completed robustly or regularly. They did not identify concerns we had found during the inspection and did not always record the action required when areas for improvement had been found.

Suitable numbers of staff were employed to provide the care and support required. Some parts of the day did not appear to have the numbers of staff required to ensure people always received the care they needed and wished for in a timely way. We have made a recommendation about this.

Effective recruitment procedures were in place to check that staff applying for positions were of good character and suitable to provide care and support to people living in the service before they were employed.

The premises were clean and well maintained providing a pleasant environment to live in. All areas of the home were accessible to people no matter what their mobility needs. All essential servicing of utilities and equipment were carried out at appropriate intervals as advised by the relevant professional bodies. Fire testing, servicing and evacuation drills had been completed and recorded.

People were supported to gain access to health care professionals when their health needs changed and they became unwell and to maintain their health and well-being. People were very complimentary about the food and the choices they had at mealtimes. People's specific dietary requirements were met and kept up to date.

People and their relatives had very positive comments to make about the staff and their caring attitude. Staff clearly knew people well and created an environment where people felt safe and comfortable.

Activities were provided to suit the preferences of people living in the service. An activities coordinator planned activities and external entertainers were also regular visitors to the service.

Complaints were dealt with by the registered manager and they shared outcomes with the staff team to make sure lessons were learned. The registered manager had a range of initiatives in place to gain the views of people in order to improve the service provided. The provider carried out an annual satisfaction survey with people and their relatives. They analysed the results and comments made to improve areas identified.

We received many positive comments from people, relatives and staff about the registered manager and how they managed the service. They were seen to be approachable with an open door culture to listen to views and concerns.

During this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some elements of medicines administration were not managed well.

Individual risk assessments were not always completed to identify risks and protect people from harm. Accidents and incidents were not always recorded and monitored appropriately. Staff did not have a clear understanding of their role in protecting people from abuse.

Suitable numbers of staff were not always deployed appropriately throughout the day to respond to people's needs. Safe recruitment procedures were in place.

The premises were suitably maintained and equipment was appropriately checked.

Is the service effective?

Requires Improvement

The service was not always effective.

Nurses and staff had not always kept the basic training required to carry out their roles up to date. Staff had not always had the opportunity to regularly meet individually with their line manager.

People were not supported appropriately to ensure their basic rights were upheld within the principles of the Mental Capacity Act 2005.

Care plans were not person centred and up to date with people's needs and preferences.

People were positive about the food they were served and were supported to maintain their dietary requirements.

People were supported to access health care professionals for advice and support.

Is the service caring?

Good

The service was caring.

People were very positive about the care and support they received from staff. The staff approach was kind and caring .

People were supported in a respectful way by staff who were mindful of their privacy and dignity.

Information was recorded about people's family and personal history to enable staff to have a holistic view of the person and what was important to them.

Is the service responsive?

Good

The service was responsive.

Complaints were investigated and outcomes recorded. Lessons were learned to improve people's experience.

People were happy with the activities provided and said they were given the choice to join in or not as they wished.

Care plans were reviewed regularly and people and their relatives were asked about their care and treatment.

The provider and registered manager sought people's views of the service in a variety of way in order to make improvements.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider and registered manager had a system of audits in place to check the quality and safety of the service. These were not always carried out regularly and where improvements were required these were not always recorded and actioned.

People, relatives and staff were very positive about the registered manager and found them to be friendly and approachable.

Links had been made with a local school and church by the provider and registered manager to increase community participation.

Valley View Care Home Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 19 December 2017 and was unannounced. The inspection was carried out by one inspector, one specialist nurse advisor and an expert by experience who has experience of family members living in a care home. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke with seven people who lived at the service and three relatives, to gain their views and experience of the service provided. We also spoke to the registered manager, the deputy manager and five staff including registered nurses.

We spent time observing the care and support provided in communal areas and the interaction between staff and people. We looked at five people's care files, medicine administration records, four staff recruitment and nine staff supervision records as well as the staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

We asked the provider and registered manager to send us further information following the inspection and they sent this within the time requested.

The service had been newly registered with us since December 2016 when the provider changed their legal entity. This was the first inspection carried out on the service since the change to check that it was safe, effective, caring, responsive and well led.

Inadequate

Is the service safe?

Our findings

Improvements were required in the management and administration of people's prescribed medicines. All aspects of medicines management and administration was managed by registered nurses. The new four weekly cycle of medicines had commenced the day before the inspection. This meant medicines had been newly signed in to the service from the pharmacy and a new medicines administration record (MAR) had commenced the day before. Three medicines had not been signed for, one the day before inspection and two on the day of inspection. The medicines appeared to have been given as they were missing from the stock. Balances of medicines carried forward from the previous month were not always recorded. We were unable to assess the balance of one medicine as tablets had been carried forward from previous cycles but there was no recording made of the number of tablets actually carried forward. We also checked one person's painkiller, Paracetamol, which was prescribed on an 'as needed' (PRN) basis. The medicine was not entered on the MAR at all. The nurse in charge told us the person was still prescribed the medicine. The nurse added the Paracetamol to the MAR by hand, however, they did not ask another member of staff to check and witness the addition which was standard protocol.

Protocols were not in place to provide guidance to staff about the use of PRN medicines when administering these to people. Guidance should be available so nurses administering medicines knew what the medicine was used for, why people were prescribed the medicine, the side effects to watch out for and the safe levels to take in a 24 hour period. Assessments had not been undertaken to check the effectiveness of the use of PRN medicines, such as painkillers, to make sure the most appropriate medicine was prescribed to relieve people's symptoms. One person told us many times they were in pain during the inspection. On checking their medicines records it was clear they were prescribed pain relief. However, the effectiveness of this was not assessed and there were no regular pain assessments. The registered manager told us the person had already received Paracetamol for pain relief and could not be administered any more at that time. As a review had not taken place it was difficult to make a judgement whether the pain relief was effective and controlled the person's pain successfully. A pain care plan was in place for each person, however, monthly reviews did not fully evaluate people's pain and their continued need for pain relief. People did not have a care plan to record the individual care and assistance each person required when taking their medicines. This meant there was no evidence that people had been given the opportunity to voice their preferences and needs when taking their medicines. Nurses may not have had the personal information needed to take a person centred approach when administering medicines, particularly new staff or agency nurses if used.

Some people had thickeners prescribed to add to their drinks to prevent the risk of choking. Due to the risks associated with thickeners by accidental swallowing or incorrect measurements, thickeners must be stored in a locked cupboard as other medicines are. Thickeners must only be given to those for whom they are prescribed. We found cartons of thickeners stored in an unlocked cupboard sited on a communal corridor. This meant that people were at risk of ingesting the thickener putting them at serious risk. The prescription labels had been removed from the cartons of thickener. This meant the thickener may be used for people who were not prescribed it or the wrong amount administered to those that were, placing people at serious risk of harm. We did not observe these thickeners being used during the inspection. The registered manager removed the cartons of thickener form the unlocked cupboard and stored them correctly during the

inspection.

A medicines audit was completed by a nurse once a month to check people's medicines were being administered safely. The nurse checked the medicines for each person as they arrived into the service from the pharmacy. The medicines received for each person, the amount received and the date was recorded on the audit. The nurse checked the amount of medicines left two weeks later to make sure none were missing or a surplus. However, the audit did not include medicines already held in the service. For example, PRN medicines such as Paracetamol that were already in stock. This meant there was a risk that errors could have been made and gone unnoticed. We found that some months were not audited at all. Two consecutive months in the summer of 2017 medicines were not checked. This meant there was a three month gap when medicines may not have been administered safely. Gaps were seen in audit records where some medicines had not been counted and no explanation was made for this. Liquid medicines were not checked. A packet with sachets of powdered medicine had been checked during one audit and had shown that eight sachets were remaining when there should have been 14. No explanation was given or action taken. A question mark had been recorded next to some medicines when audited but no reason given why this was or if any action was taken. The registered manager had not been made aware of these anomalies. We also found that medicines had been counted in to the service on 20 November 2017 and had not been checked two weeks later as was expected. No check had been carried out up to the date of the inspection, 19 December 2017. We asked the registered manager about this who said this had not been completed because the nurse responsible was absent in early December 2017. They could not account for why the two months of audits earlier in the year were missing. The registered manager told us the responsibility for medicines audits was not delegated to another nurse at times of absence. This meant the system to check the safety of medicines administration was not effective as consistent processes were not in place. The registered manager had not noticed the medicines audits had not been completed every month as expected.

The failure to ensure the safe management of medicines administration is a breach of Regulation 12(1)(2(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The management of medicines in relation to the ordering, storage and returns of medicines was safe and effective. Temperature recordings were made and documented daily for both the room the medicines were stored in and the medicines fridge. It is important to check and control the temperatures medicines are stored at as the incorrect temperature may affect the efficacy of some medicines. Nurses were able to explain what they would do if any of the temperatures rose above the recommended values. Controlled drugs were stored and documented appropriately.

Staff did not have a clear understanding of the procedures to safeguard vulnerable people and their responsibilities in keeping people in their care safe from abuse. For instance, staff did not know who to report to outside of the service if they had concerns about the welfare of people within the service.

We found security to be a concern. There were two sluice rooms, one on the ground floor and one on the first floor. The doors of both sluice rooms were not locked although a key was available hung above each door. A sluice room is where used disposables such as incontinence pads and bed pans are disposed of, and reusable products are cleaned and disinfected. Cleaning machines were in use within both sluice rooms which meant people were at risk of the potential harm of equipment and cleaning products if they walked in to the unlocked rooms. Disposable razors were found lying on the windowsill in the sluice room on the first floor. Safe disposal units such as a sharps box were not available for staff to safely discard those sharp items. This meant that people were at potential risk of serious injury and cross infection from sharp razors if they entered the unlocked area and picked these easily accessible items up. A sharps box was found in the ground floor sluice room to dispose of such unsafe items.

Some individual risk assessments were in place to identify risks and make sure steps were in place to protect people from harm. One person was at risk of falling out of bed and required bed rails in place to keep them safe. A risk assessment had been completed showing the risks of potential injury. Staff were guided to check the bed rails hourly to make sure they were securely in place and other measures such as having padded bumpers to protect from bruising. Risk assessments were reviewed monthly. However, some risks had not been assessed when concerns were identified. One person's mobility had deteriorated and this had been identified in their care plan. The care plan review on 19 September 2017 showed the person sometimes required a hoist to support their movement. However the moving and handling assessment in place since 26 January 2016 stated the person walked with a frame with supervision. The assessment had been reviewed each month with 'no change' recorded.

Some people were unable to use a call bell to call for assistance if needed. There was poor evidence of checks being maintained. A 'resident contact sheet' was in place for some people but this was not always completed regularly to show that staff had checked regularly on people to make sure they were safe.

Accidents and incidents had been recorded by staff some of the time, however, we found incidents had happened that were not recorded as such. This meant action to prevent future occurrences may be missed. One person had sustained two skin tears in one day. This had been recorded on a body map placed in the folder for daily recording. However, the incident had not been recorded appropriately as an accident or incident as staff did not always recognise what was an incident. The person's records stated, '[They] were probably scratching'. Investigations into the incident had not been undertaken or steps put in place to prevent a re-occurrence. Another person had sustained a bruise on their thumb. This was not recorded appropriately to ensure investigation as to what happened and suitable steps put in place to prevent it happening again.

The provider and registered manager had failed to assess or mitigate risks to people's safety effectively. This was a breach of Regulation 12 (1)(2)(a)(b)of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

All the people we spoke with and their relatives told us they felt safe living at Valley View Care Home and would feel confident speaking to any staff member if they had a concerns. The comments we received from people included; "It feels safe, it's like home, feels homely, staff are very nice to me. I have no complaints, if I have an issue I would talk to one of the staff", "I feel safe. I feel this is a kind place, all quite happy people here" and "At home I kept falling over. I feel safer here, quite comfortable and everyone is friendly".

Relatives who were visiting told us; "He is well looked after, they (the staff) love him to bits, no qualms whatsoever with staff. I would talk to the [Registered manager] if I felt something was wrong", "It feels like a safe environment, staff are very gentle and always talk to mum. Staff always recognise me when I visit" and "He appears well looked after. He tells us they have regular fire alarm tests".

There were suitable numbers of staff available at some times of the day but not others. Morning staffing was suitable as nine staff including nurses were available to meet people's care needs. Staff were present in the lounge when they were supporting people to sit in the lounge after being assisted to get up from bed, so were able to give people drinks and attend to any assistance requested. The afternoon and evening rotas showed less staff, with five staff including nurses available. Staff told us they felt they worked to a routine in the service and they needed to encourage people to go to bed as soon as possible after lunch as the staffing numbers were significantly lower in the afternoon. Although staff were clear they worked well as a team and they always did their best for people they did not feel they were always able to provide person centred care. This was borne out by our observations during the afternoon. Very few people were left sitting in the lounge

after lunch. There was a period of more than 15 minutes after lunch when no staff checked on people in the lounge as they were busy elsewhere. People were left unattended until an external entertainer arrived who was commissioned to deliver activities once a week. They were visiting in the afternoon as planned to support people to engage in exercising to music. There were so few people left in the communal lounge the entertainer revised their planned and advertised activity to cater for the small amount of people. No staff were available to assist during this time.

The provider used a dependency assessment tool to measure the assessed needs of people. The dependency assessment was reviewed each month and we could see how the scores had increased when people's needs changed. One person's dependency assessment showed they had a medium level of need until 28 September 2017 when their care needs changed and the level increased to high need. There was no evidence of how the dependency assessments of people's care and support needs was used to determine the staffing levels used in the service.

People told us they did not have to wait long when they required staff attention. One person said, "It depends on the staff if they are busy with another call you have to wait" and another said, "You cannot always expect immediate attention, at night only 2 staff on. You just wait your turn, they (the staff) always come". However, call bells became more active during the afternoon and we found they took longer for staff to answer as they had earlier in the day. There was an almost constant noise from call bells in the second part of the afternoon.

We recommend the provider seeks advice and guidance from a respected source to determine the levels of staff required based on dependency assessments to ensure suitable numbers of staff are available throughout the 24 hour period.

A detailed and easy to understand personal emergency evacuation plan (PEEP) was recorded within people's care plans. A PEEP sets out the specific physical, communication and equipment requirements that each person had to ensure that they could be safely evacuated from the service in the event of a fire. The information is required to advise on the level of assistance each person needed was available for staff and emergency services in such a situation. Each PEEP was reviewed monthly by the registered manager to ensure the information was current and up to date.

The provider had safe staff recruitment practices, to ensure that staff were suitable to work with people living in the service. Staff told us that they had been through an interview and selection process before they started working at the service. Checks had been made against the Disclosure and Barring Service (DBS). This highlighted any issues there may be about staff having criminal convictions or if they were barred from working with people who needed safeguarding. Application forms were completed by potential new staff which included a full employment history. Where a full employment history had not been given on the application form, the registered manager followed up any gaps with the applicant at interview. The registered manager had made sure that at least two references were checked before new staff could commence employment. The nurses Nursing and Midwifery Council (NMC) PIN numbers were recorded and a system in place to check when the nurses registration with the NMC was next due. The provider was following safe recruitment policies and guidance when employing new staff to the service.

The service was kept clean by domestic cleaners working each day. This meant staff could concentrate on their caring role rather than having to carry out general cleaning. The registered manager made sure personal protective equipment (PPE) was available for staff to use when providing personal care to people. This included items such as disposable aprons and gloves. We saw staff using these during the inspection. However, sometimes we saw staff walking around the communal corridors with their disposable PPE on

which was not appropriate due to the risk of spreading infection.

All essential maintenance of the premises and servicing of equipment was undertaken at appropriate times. For example, electrical installation testing, gas safety, portable electrical appliance testing and fire alarm systems and equipment. Equipment such as hoists and bath chairs were serviced regularly as recommended by the appropriate contractors. The premises were designed to be accessible to all people living in the home no matter what their mobility needs were

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA 2005) 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.

A 'Resident choice sheet' was in place. Staff asked people a range of questions about their preferred everyday choices. For example, 'Where would you like to have breakfast', 'Where would you like lunch', 'What do you like to do through the day' and 'When do you like to get up and when do you like to go to bed'. However, the resident choice sheets were not completed fully so did not give an overall picture of people's preferences. One person's resident choice sheet was mainly blank. Only two questions were asked and those did not answer the actual question posed on the sheet. We found that all people had breakfast in bed before they were supported to attend to their personal care needs and get out of bed. Although many people may have preferred this, we found no evidence documented in care plans to show that people preferred to stay in bed until later in the morning.

An 'Abbreviated mental test score' was completed to assess people's mental ability. The assessment consisted of a list of questions to ask people such as their age, who the queen was and the time and date. This is generally used to quickly test if people may be living with dementia or are confused. The tool is not used to assess their capacity to make choices or decisions. People did have a mental capacity care plan which recorded their ability to make day to day choices. Such as choosing their meals or the clothes they wore. However, mental capacity assessments had not been completed for those people who may lack the capacity to make some or all of their own decisions. Where people did appear to lack the capacity to make decisions, there was no evidence that decisions had been made in their best interests.

People had been asked to give their consent when necessary. For example, people had been asked for their consent to receive care and treatment, to have their photograph taken for identity purposes or if they needed bed rails fitted to keep them safe. In some cases a loved one had appropriately signed consent for some people where they acted as Lasting Power of Attorney (LPA) to make health and welfare decisions on their behalf. However, in other cases, where people had an LPA to support decisions around their finances, consent forms had been signed when they did not have the authority to do so. An appointed LPA can only sign consent to care and treatment if they have been appointed as LPA for health and welfare. There was no evidence of best interest's decisions having been made with the relevant people where people did lack the capacity to sign consent.

Staff we spoke with had a poor understanding of the MCA 2005. We asked a nurse if any people had mental capacity assessments in place. The nurse did not know what these were. Other staff we spoke with also had a very limited understanding of how the MCA 2005 related to their role supporting people who may have limited capacity. Training records showed that many staff had either not completed training in MCA 2005 and DoLS or their training was out of date. The provider stated this training must be updated every three

years. Out of 29 care staff, seven had not completed the training and the training of 11 other staff was out of date. Out of six registered nurses, the MCA 2005 and DoLS training of four of these nurses was out of date, including the registered manager.

The provider and registered manager failed to ensure appropriate systems were in place to ensure people's basic rights within the principles of the Mental Capacity Act 20015 were upheld. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People told us they were encouraged and supported to make their own choices through the day. One person said, "When I have a wash they always ask what areas I want help with. They always put soap on the flannel for me and leave me to it. They then help me with my back, legs and feet". Another person told us, "Staff are very nice, always ask me what I want to wear today. I like to wear stockings and staff help me to get them on".

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. 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 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made appropriate DoLS applications to the supervising authority and kept these under review.

An initial assessment was undertaken before people moved into the service to enable the registered manager to decide if staff had the skills and training necessary to provide the care and support the person required. One person who had been admitted for respite care six days before the inspection did not have a care plan in place to provide the information and guidance required for staff to be able to provide the specific and individual care the person needed assistance with. We were told the person had a pressure area and so required particular care. A plan was not in place to ensure the consistency of care required to prevent deterioration in the person's skin.

A range of care plans were in place documenting the care and support people required with their assessed care needs. These included; safe environment, privacy and dignity, communication, eating and drinking, personal hygiene, mobility, skin integrity and mental capacity. There was little information to enable a person centre approach to care planning. Each person's care plan focussed on similar areas. The care and support people required to maintain their health and well-being was not always followed through. One person had a history of urine infections. Their care plan said they needed to drink at least one and a half litres of fluid a day. We found the person's food and fluid charts were not recorded consistently and therefore gave the impression they drank very little fluid on a day to day basis. Evidence showed that recordings were often not made until mid or late afternoon. On 18 December 2017 no records of fluid taken had been made until 15.00 and the total recorded for the day was 400mls, 1100mls less than recommended. On 17 December no records of fluid taken had been made until 14.00 and the total for the day recorded as 800mls, 700mls less than recommended. On 16 December 2017 1025mls were recorded as having been taken and on 15 December 2017 only 200mls was recorded as a total of fluids taken throughout the day. A similar picture was seen for all the previous days in December 2017. The same person's food chart had not been completed by staff to record the person's lunchtime meals six days out of seven from 11 December to 18 December 2017. Another person's care plan said they needed the assistance of staff to change their position regularly to prevent pressure sores developing. However the person did not have a chart for the staff to record each time they helped them to turn over. We asked a member of staff about this and they told us, "They do not use turning charts here". One person was nursed in bed and throughout the day of the inspection was positioned on their back. A body map completed on 17 September 2017 showed the person

had a pressure ulcer. However, their care plan stated their skin was intact. We asked a nurse whether the person had a repositioning chart and they said, "[They] are always on [their] back no matter what you do". However, there were no records to evidence the nurse's and staff's attempts to reposition the person to prevent a deterioration in their skin integrity. This meant people may not get the individual support they required to remain healthy and well.

One person had been referred to the community mental health team (CMHT). The report by the CMHT stated staff had reported behaviour that others may find challenging. However, a care plan was not in place with a description to advise staff how the person's behaviour may present. Or with guidance for staff to show how they should approach the person when they were upset to prevent further distress or risk to the person or those around them.

A person was complaining of pain during the inspection. On checking their care plan it was clear they were prescribed pain relief. However, the effectiveness of the pain relief prescribed had not been assessed. There were no regular pain assessments or recordings of the effectiveness of pain relief for those prescribed it. Every person had a care plan relating to pain, however, they were not person centred and monthly reviews did not effectively evaluate people's pain and need for pain relief.

The failure to provide care and treatment that meets people's specific needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People thought staff had the skills to provide the care and support they required. One person told us, "Staff are well trained, they know how I like being looked after" and another person said, "Every day staff have to hoist me out of bed, they always check if I am okay before they move me". However, we found that staff training was not always up to date and staff did not have a good knowledge of some important subject areas including safeguarding vulnerable adults and Mental Capacity Act 2005.

The registered manager told us staff were expected to update their mandatory training once a year. Some training was in the form of reading material and an associated workbook. Staff completed test within the workbook which was then marked externally. Face to face training in a group was undertaken to complete annual refresher courses the provider considered essential. This included seven separate subjects to study in one day including; moving and handling, fire safety, food safety, safeguarding vulnerable adults, first aid, infection control and health and safety Some training was completed as online courses. The registered manager told us they found the different elements of training delivery worked well. However, we found that some staff training was out of date and had not been checked by the provider or registered manager. Many staff had not completed training that was included on the provider's training schedule. For example out of 29 care staff, only one member of staff had completed hand hygiene training; only five care staff had completed pressure area care training when staff were providing care to people who were nursed in bed and therefore at risk; seven staff had completed dementia care training when people living with dementia lived in the service and nine had completed nutrition and hydration training when some people staff cared for were at risk of malnutrition. Staff told us they found completing the refresher training in one day to be quite difficult. They said they did not think they took it all in as it was a lot to remember in one day. One member of staff said, "It's a very long day so I forget what I learnt at the beginning of the day". We found a lack of understanding amongst staff of how to safeguard people in their care from abuse. The training to give staff this knowledge was included in the one day training along with six other subjects. This meant not all staff had the skills and knowledge required to carry out their role well.

Not all registered nurses had completed some training. For example, out of six nurses; only three nurses, including the registered manager, had completed dementia care training even though they were

responsible for developing care plans and risk assessments for people who were living with dementia in the service; only three nurses had completed care and management of diabetes training when people who had diabetes were living in the service and only two nurses including the registered manager had completed pain management training when all nurses were responsible for administering medicines.

Not all staff had the opportunity to have regular one to one supervision meetings with their line manager. Supervision meetings are a way to provide staff with the necessary support, constructive criticism and personal development to be able to carry out their role successfully. In the last 12 months, out of nine staff supervision files we looked at; two nurses had no supervision meetings and one nurse had one meeting. We did not see evidence that this included the clinical supervision required to make sure registered nurses kept their professional skills updated to maintain their registration and to ensure they continued to have the professional expertise to responsibly care for people. Two care staff had only one meeting, three had two meetings and one had three meetings. This meant staff did not have the individual support and guidance to enable their personal development and success in their role.

The provider and registered manager failed to ensure registered nurses and staff had received the necessary training and supervision to be able to successfully carry out the role they had been employed for. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People were supported to gain access to health care professionals when required. One person told us, "If I ask, staff will make an appointment for me with the optician or chiropodist who cuts my toe and fingernails for me. I have recently got new glasses". Another person said, "(Name of staff member) is coming with me to hospital for my appointment. She stays with me all the time. Very chatty person and stops me from being nervous". A relative told us their loved one had recently been ill, "The doctor was called and medicine was prescribed. I was informed straight away". The GP visited regularly to monitor people's health and to respond to requests from nurses when they raised concerns about a person's health. The GP had reviewed a dementia care plan for one person and completed this annually. People had been referred to a dietician for advice when they had lost weight. One person had lost weight. The registered manager reviewed their weight record and referred them to a dietician who prescribed a nutritional supplement. The person started to slowly gain weight again.

We received good feedback about the food choices and the quality of food from people. The comments we received about the food included; "No complaints about the food we get. There is always plenty of choice", "The food is good, not much left on the plate" and "Food is very nice, if you don't like one meal there is always another choice. I am having mine early today as I have a hospital appointment this afternoon". Relatives were equally as positive about their experiences of the meals they had observed and their loved ones comments about the food to them. One relative said, "The food is always nice" and another told us, "Dad has a huge appetite for food. Seems to enjoy it, it looks appetising and healthy. They (the staff) always take into account his sugar level when offering sweet puddings".

People had the choice of sitting in the lounge in their armchair to eat their meal or sit at the table in the dining area. Some people had their meal served in their room, either because they chose to or because they were nursed in bed. The cook was aware of special diets and consistencies of food people had been recommended by health care professionals. For example, people who had diabetes or those who required a soft or pureed diet due to choking risks. The cook served the meals from a heated trolley using their up to date menu and diet sheet, giving staff the correct food choice and/or diet for each person. Pureed and soft meals looked colourful and appetising with each food item pureed separately.

Good

Is the service caring?

Our findings

People told us they found that staff were kind and caring. They described the staff as happy and always cheerful. The comments we received included; "They always ask if you are alright and look after you well", "Nothing is too much trouble, you only have to ask. Always have a good laugh with them", "Yes all the staff here are very caring. They are very good, everything done the way you want it", "The staff are very nice, very chatty and friendly" and "The staff are always very helpful and cheerful. I have a lot of fun with them".

The relatives we spoke with were very happy with how their loved one was cared for. One relative said, "She is always clean, her nightdress is always fresh every day, she never smells and the laundry always comes back feeling soft and fresh". Another relative told us, "Well looked after and always well groomed. When he is up and about he is smartly dressed. Occasionally I have seen him wearing his tie" and "If dad is in bed staff will stop as they walk past and ask, 'Are you okay (name)?' They seem genuinely concerned about his wellbeing".

A life history was included in people's care plans. The life history recorded important information about the person including; where they were born, details about their parents and siblings, their occupation, if they were married and details about children and grandchildren, favourite colour, food and drink. This helped staff to have a good understanding of each person, what was important to them and their preferences.

The registered manager knew people really well as they made sure they worked on shift caring for people as well as carrying out their management role. We observed caring interactions between people and staff and also heard staff talk about people in a warm but professional manner. One person thought they had not had anything to eat. A member of staff was understanding and patient, describing what the person had eaten through the day, reassuring them and encouraging their memory. A member of staff said, "I love it here, I'm always happy to work, even at Christmas". One person said they had a pain. A member of staff said, "Right, I am going to help you move to another chair so you are more comfortable and then I will get the nurse". The staff member then came back to tell the person they had informed the nurse who would come to see them.

Interactions between staff and people were kind and caring along with some laughter and banter. People smiled when staff approached them and were happy to be helped. Staff took time to reassure people that the hairdresser would come and collect them when their appointment was due. Staff regularly complimented people about their hair after their hair appointment. People were dressed in clean coordinated clothes and looked clean and well cared for. One person who was living with dementia whose verbal communication was limited wore a necklace and bracelet and staff took the time to compliment them on their appearance and tell them how lovely their jewellery looked.

Throughout the morning one staff member regularly came back into the lounge to reassure the person they were escorting to the hospital in the afternoon. The staff member discussed with them the time and arrangements made for an early lunch so that they would be ready for the ambulance transport. After their lunch staff asked the person where they would like to sit while they were waiting to leave for their appointment and they chose to sit by the window looking out at the front door.

Staff responded quickly to peoples request for help. One person told staff they felt cold and a staff member responded by offering to get a cardigan from their room and asking which colour cardigan they wanted.

People told us they were treated with dignity and respect. One person said, "I always keep my door open, they (staff) always knock before they come in". A relative told us, "No complaints from me. As far as I can see the staff always respect people's dignity, they always close the door when getting him washed or changed. They always knock before they come in".

People's dignity and right to privacy was protected by staff. One person spilt their drink onto their lap. They called out for assistance and a staff member immediately attended to them, suggesting they support the person to go back to their room for a change of clothes. When people sitting in the lounge asked for assistance to go the bathroom, staff were seen to help them discreetly, so that people were treated in a dignified way in front of others. Staff knocked on people's bedroom doors before entering. Bedroom doors were closed when personal care was being delivered. Most people chose to have their bedroom doors open which allowed them to see and chat with people and staff passing by.

People's confidential records relating to their care were kept by the provider in a locked cabinet in the office to maintain people's privacy.

Good

Is the service responsive?

Our findings

None of the people or relatives we spoke with had needed to make a formal complaint. They said they would be happy to approach the registered manager, the provider or the staff if they did have a concern they wished to raise. One relative told us about a misunderstanding about their loved one's care when they first moved in to the service. They said, "We spoke to staff, they listened and it has never happened again". Another relative told us, "I have never had to make a complaint but if I had to I would go and see [Registered manager]. She is very approachable".

Complaints had been recorded when they had been made and the outcomes of complaints were used to ensure lessons were learned in order to improve the service provided. Records of staff meetings showed the registered manager had raised the learning they needed to take from complaints as a staff team. Most complaints had been dealt with according to the complaints policy and evidence was available that showed the registered manager had responded to the complainant with the outcome of their investigation. We did note one complaint that had been discussed in staff meeting minutes that had not been included in the complaints file. We spoke to the registered manager about this who made sure they added the details to the formal complaints records.

Relatives told us that they and their loved one's views were taken into consideration when decisions were made about their relatives care and treatment. One relative told us how their loved one was used to specific meals at certain times of day and they wanted this to continue while they were staying in the service. They said, "I feel I am listened to, I did have a concern that they [staff] were not able to give her soup for lunch as it was staff change over time, but today I can see she had it on time". Another relative told us their loved one liked to try and stand up independently but couldn't do it without falling. They said, "The nurse and staff spoke with me about putting up the safety rails whilst [they are] in bed. Staff always take time to explain to me what is happening with [my relative].

Care plans were reviewed every month and more regularly if there was a change in circumstances or in people's assessed care needs. One person's care plan showed changes had been made to their communication care plan on 12 December 2017. The person had become less able to verbally communicate and their care plan was adjusted accordingly with guidance for staff to be able to provide consistent support to the person.

People were happy with the range of activities on offer and thought they had enough to choose from. The comments we received about activities included; "If there is not much to do I read the newspaper, one of the staff brings it in for me every morning", "I think there is enough activities, I join in if I feel like it. I am having my hair done today and will look fabulous after that", "I enjoy the exercise classes, we have a bit of fun, lots of laughing", "I like bingo and the armchair exercise, I wave the scarf to music. I always watch [two games programmes] on the TV. We have a shopping trip to Hempstead Valley every couple of months".

The provider employed an activities coordinator who worked part time. The activities coordinator was not available on the day of inspection as the hairdresser visited that day every week and many people liked to

have their hair washed and styled or cut. The hairdresser knew people well and knew how they liked to have their hair done. The registered manager had arranged external activities providers to visit regularly to provide extra activities. These included exercise and dance based classes to suit all abilities. However, the external provider visiting during the afternoon of the inspection to provide an exercise class to music had very few participants. People were taken to bed for a rest after lunch and we did not see or hear people being encouraged to stay in the lounge to take part. Although one person told us, "I sometimes like having a sleep in the afternoon. Staff always ask me whether I want to stay up for the activity or go back to my room after lunch".

Planned activities were advertised on a board in the communal lounge area and on a notice board in the main hallway. Some people chose to stay in bed most of the time although some occasionally joined in activities in the lounge with encouragement. This was clearly recorded in their care plan. Some people liked to have a newspaper delivered every day and the registered manager arranged this.

People said there was a religious meeting held at the service and they could choose if they wanted to attend. Details of when Holy Communion was available were displayed on the activity board. One person told us, "We had a religious service yesterday, people came in and sang carols with us" and another person told us, "The vicar comes regularly, it is up to you whether you want go to the service or not".

People and their loved ones were asked about the end of their life. A care plan was in place documenting where people would like to be at the end of their life, and if they wished to be resuscitated. The care plan also recorded if another person had been asked to be Lasting Power of Attorney (LPA) to make decisions on their behalf if they were unable to do so. Where people had a LPA in place, the registered manager had checked to make sure this was in order to ensure the person's rights were upheld.

The registered manager held meetings with people living in the service once a year so that people had an opportunity to voice their views and ideas. A meeting was held on 12 April 2017 when people talked about the activities on offer and what else they would like to do. They also discussed the food and mealtimes. All the people who attended were in agreement the food was good. The registered manager also held 'focus groups' with people. The intention of the focus groups was to have an open discussion of one agreed subject. One group held on 6 December 2017 focussed on communication. A discussion was held about how communication worked in the service and how people were helped by good communication. All present at the focus group gave their own individual experiences of communication within the service, which was all positive. Another focus group held on 10 March 2017 discussed aging. A member of staff was planning to hold a session with 15 to 18 year olds about aging and what it means to people and wanted to get the focus group's thoughts to take to the younger people. The record of the meeting showed a long and lively discussion that people really engaged in and shared their thoughts openly. Another way of gaining people's views was through 'Tea with matron' once a month. The registered manager met with any people who wanted to join in and the purpose was to have a conversation. People could chat about any subject they wanted and often included something topical, current news or events. At a tea with matron meeting on 6 November 2017 the conversations that took place included; fireworks, Remembrance Day, how the Queen and Prince Phillip worked hard, the Invictus games and Prince Harry's involvement and the current weather. The tea with matron meeting on 9 October 2017 included chats around; favourite radio programmes, the novelty of the TV when it was first in people's homes, the autumn season, the clocks going back one hour meaning evenings would be darker and a planned coffee morning in aid of charity.

The provider asked people to complete a satisfaction questionnaire and sent questionnaires to relatives and friends. Twenty people took part in completing the questionnaire in June 2017. A range of questions about the quality of the service were asked and people had the opportunity to make further comments which they

did. Most people were either 'happy' or 'very happy', with one or two people 'satisfied' when answering the questions. The provider completed an analysis of the survey. Action required to make improvements as a result was recorded. Only two relatives returned their questionnaire in June 2017 and one of those was incomplete. The provider therefore was unable to make any useful analysis of the results. The provider and registered manager used various initiatives to gain people's views of the service so people had a choice in how they took part.

Requires Improvement

Is the service well-led?

Our findings

The registered manager took responsibility for the majority of record keeping, monitoring and auditing in the service. The registered manager told us care plans were audited once a year, however we found care plan audits were carried out less than once a year. Of the six we looked at none had been checked once a year. For example, one person's care plan had been audited on 29 January 2017 and previously on 19 July 2015, another person's plan had been audited on 6 March 2017 and previously on 15 August 2015. This meant these care plans were not checked and audited for 18 months. We found only 23 care plan audits in the file when 30 people were living in the service and each had a care plan. Where the registered manager found areas for improvement, such as reviews not being completed or plans not being in place, the action to remedy the issue was undertaken by the registered manager and not delegated to a nurse or member of staff. For example, to the nurse or staff member who should have carried out the action in the first place, therefore developing their skills and responsibilities and learning how to improve.

As part of the provider's quality monitoring system the registered manager was expected to carry out a 'Manager's spot check' every two weeks. However, this had not taken place since 6 February 2017 when very little observation was recorded. 'Resident comfort checks' were undertaken every three months, although none had been completed since 5 September 2017. The intention was for the registered manager to carry out a visual check and ask people questions to check if they were comfortable, well cared for and find out their experiences of the care they received. A group of questions to ask people were identified on the monitoring form to check this. However, only four people were actually asked the questions on 5 September 2017 and 12 people were asked the questions at the previous comfort checks on 21 June 2017. The recording made for most people was, 'in lounge', or 'asleep' or, 'unable to answer'. This meant a useful analysis could not be made of the results of the comfort checks in order to implement improvements to the service provided.

An infection control audit was carried out most months. The areas on the monitoring form that required inspection were not all completed, many were left blank and no action was recorded as being required. This meant the provider and registered manager could not be assured safe procedures were being followed to prevent the spread of infection. We also found the medicines audit had not been undertaken as regularly or to the required standard in order to ensure the provider and registered manager could be assured of the safe management of prescribed medicines.

The failure to have an effective system in place to identify and make improvements to the quality and safety of the service provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us they felt the service was well managed and they found it easy to talk to the registered manager and the provider. People told us they felt they were listened to and all the staff were very good at answering their questions. People told us; "The manager is nice and doesn't mind what she does for you, always there to help out. Nothing is too much trouble for her", "I know I am being well looked after here" and "Most mornings [Registered manager name] comes around. She is very nice and easy to talk to".

A relative told us, "I get on well with [Registered manager] she always gives us time to talk. Its home-like. Since dad has been here I have had no qualms about his care. I know I made the right decision picking this home. I am extremely pleased with the care he gets".

Staff spoke highly of the registered manager and found them to be approachable and supportive. People thought the staff worked well together. One person told us, "You can see from their attitude they work well together. They all help each other out, they are always happy" and another person said, "(Named) staff members work well together we always have a bit of fun when they are helping me in and out of bed". The staff we spoke with said the staff team worked well together and they all supported each other, led by the registered manager. The registered manager held regular staff meetings to provide updates and guidance to staff. The type of discussions held at staff meetings included; the staff dress code, daily tasks expected to be carried out, personal mobile phone use, infection control and good timekeeping. Time was allocated to discuss concerns staff may have about the health and care of people living in the service. Staff told us they had a two week rota that repeated, so they were able to plan their personal life and time off. This helped to support the well-being and satisfaction of staff.

The provider and registered manager had made links with a local school and a local church. People were invited to Christmas events at the school such as Christmas parties and students visited with Christmas gifts. Parishioners from the church visited each month.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report in the reception area.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The registered manager had notified CQC about important events such as deaths and serious injuries that had occurred since the provider's new registration with CQC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to provide care and treatment that met people's specific needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager failed to ensure appropriate systems were in place to ensure people's basic rights within the principles of the Mental Capacity Act 20015 were upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to assess or mitigate risks to people's safety effectively and to safely manage the administration of medication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to have an effective system in place to identify and make improvements to the quality and safety of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to ensure staff had received the necessary training and supervision to be able to successfully carry out the role they had been employed for.