Akari Care Limited

Wallace House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19, 20 and 28 July 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Wallace House in November 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Wallace House is a care home which provides nursing and residential care for up to 40 older people, including people living with dementia. There were 37 people living in the home at the time of this inspection.

The service had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe from harm. Staff were aware of the different types of abuse people might experience and of their responsibility for recognising and reporting signs of abuse. People told us they felt safe. At the time of the inspection not all staff members were up to date in relation to safeguarding training. The service had recognised and taken action to address this.

Possible risks to the health and safety of people using the service were assessed and appropriate actions were taken to minimise any risks identified. People were assisted to take their medicines safely by staff who had been appropriately trained.

Staff had not been given the on-going training they needed to keep their knowledge up to date. Nor had they been given the necessary support, in terms of annual appraisals.

People were supported to meet their health needs and access a range of healthcare services. Nutritional needs were monitored and specialist advice was sought when necessary. People were offered a varied diet with choices of meals and, where needed, were assisted with eating and drinking.

Staff were described as kind and caring and had a good understanding of people's needs and preferences. They treated people as individuals and supported them to make choices about their care. People told us they were consulted about and involved in their care planning although we found this was not always clearly documented.

Care plans were reviewed and updated on a regular basis to reflect changes in people's needs. Consent to care and treatment was not always formally documented.

People told us they felt staff listened to them and they felt able to raise issues with management. Formal complaints were not always properly investigated or recorded in sufficient detail.

People told us they were happy with the management of the service and knew who to contact should they have any concerns. Staff we spoke with felt supported by the registered manager and were able to easily access support when they required it. The provider had a range of systems in place for monitoring and reviewing the service, however we found these were not fully effective. Record keeping around areas such as safeguarding incidents, complaints and actions taken to resolve areas for improvement was poor.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to supporting staff; consent to care and treatment; complaints; and governance. You can see what action we told the provider to take at the back of the full version of the 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?

Good

The service was safe.

The service had taken action to update staff members in relation to safeguarding training. Staff were aware of the signs and symptoms of abuse and their responsibility for reporting these.

Risks to people were assessed and appropriate measures taken to keep people safe from harm.

There were sufficient numbers of staff to meet people's needs safely.

People were assisted to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not fully effective.

The staff team had not been given all the training they required to meet people's needs. Staff had also not been given the appropriate support to carry out their roles effectively.

People had not always given their formal consent to their care.

Staff responded appropriately to changes in people's health needs and people were supported to maintain a nutritious diet.

Is the service caring?

Good

The service was caring. People spoke highly of the caring nature of the staff who supported them.

People's privacy and dignity were respected.

People were treated as individuals and encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People's needs were assessed prior to them joining the service. These needs were then re-evaluated on a regular basis.

The system for recording and responding to complaints was not effective.

People were regularly asked for their feedback on the service they received and the results of these surveys were on display in the service.

Is the service well-led?

Requires Improvement

The service was not well-led in all areas.

At the time of the inspection the service had a registered manager in post. People and staff spoke highly of the registered manager.

There was an open culture in the service that sought the views of people, relatives and staff.

Systems were in place to monitor and develop the effectiveness of the service. However these were not always effective.

Wallace House

Detailed findings

Background to this inspection

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

This inspection took place on 19, 20 and 28 July 2016 and was unannounced. This inspection was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed 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 reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities, clinical commissioning groups and Healthwatch to gain their experiences of the service. We received information of concern from Local Authority commissioners who contracted people's care. We also spoke with the local safeguarding team who made us aware of concerns raised with them in relation to the management of covert medication.

During the inspection we toured the building and talked with 11 people who lived in the home and eight visitors. We also spoke with staff including the registered manager, regional manager, two Nurses, two senior carers, five care workers and five members of ancillary staff. We reviewed a sample of six people's care records, five staff personnel files and other records relating to the management of the service. We also undertook general observations in communal areas and during mealtimes

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. People we spoke with told us they felt safe and protected from harm in the home.

The provider had a safeguarding policy and procedure in place. These documents provided details of the provider's responsibility for recognising and reporting abuse. Guidance was provided to staff on the different types of abuse and the signs and symptoms people being abused may display. Staff we spoke with were aware of their responsibilities for reporting any concerns or suspicions of abuse. However training records indicated only 66% of staff members were up to date with their safeguarding training. We discussed this with the registered manager. The registered manager told us this had already been identified as an area for improvement and safeguarding training had been arranged for 4 August 2016.

We reviewed the service's safeguarding log and found very limited records were held of safeguarding incidents. We found the log had only been created in March 2016 and consisted of a list of incidents. The log did not provide details of the type of incident or any indication of action undertaken by the service. We raised this with the registered manager and were advised full records of each incident would be held in each person's care records. We reviewed the care records for two people using the service for whom an incident was recorded on the log. One of these incidents related to a potential medication error and the other was an incident of physical abuse between two people using the service. We found evidence appropriate action had been taken by the provider on both occasions.

We asked the registered manager to send us a copy of the 'service user guide' following the inspection. Although the guide provided some information to people using the service about what to do if they had any concerns we found this was limited. The guide did not provide people with information about how the service would deal with concerns, nor did it provide people with contact details for other agencies they could report their concerns to. We discussed with the registered manager who agreed the guide could be updated to included additional information for people using the service.

The service also had a whistleblowing policy and procedure in place and staff we spoke with were aware of this. Information about the whistleblowing policy and procedure was on display in the home. Staff we spoke with told us if they had any concerns they would report these to the manager.

The service had a business continuity and emergency contingency management plan which covered the actions to be taken in order to continue the service in the event of an emergency. This plan included individual critical function analysis and recovery process documents for each identified emergency. These set out the roles and responsibilities of individual staff members in responding to an emergency and the resources that would be required. Plans were in place to respond to emergencies such as fire, evacuation of the building and the failure of essential services. Each person using the service had an emergency evacuation plan, a copy of which was kept in the service's emergency bag located near the front entrance. During the inspection the fire alarm went off on three separate occasions, we observed staff responding appropriately on each occasion.

We reviewed the service's general risk assessment folder. This contained risk assessments specific to different job roes such as catering, maintenance, care delivery and housekeeping/domestic as well as general environmental risks. Potential hazards were scored in relation to three factors; likelihood, severity and frequency. We found all the risk assessments had been reviewed within the last year and actions taken to reduce risks were clearly documented. For example under care delivery, a potential risk was identified to staff and residents when using wheelchairs. The provision of moving and handling training to staff was identified as an action taken to reduce this risk.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and water temperature and quality were undertaken. The service also had contracts in place for the routine maintenance and servicing of equipment.

We reviewed care records for six people using the service and found as part of their initial assessment potential areas of risk were identified. In the majority of the records we reviewed we found where a risk factor was identified a specific plan had been put in place to support the person. In one of the records we reviewed we found completion of the Waterlow assessment (an assessment used to highlight concerns regarding skin integrity) had identified a potential risk; however we could not find a corresponding care plan. We highlighted this to the registered manager who confirmed this would be reviewed following the inspection.

We found the moving and handling care plans for two people using the service were quite limited in scope. These did not provide specific guidance to staff about the techniques and equipment required to safely assist these people. For example one care plan stated the person required a wheelchair to transfer to and from bed. The care plan did not include details of the equipment or techniques to be used by staff when assisting this person to transfer to their wheelchair from their bed or vice versa. We highlighted this to the registered manager who confirmed these care plans would be reviewed and updated following the inspection.

We were told by the registered manager that staffing levels were based on dependency and were calculated on a monthly basis. In the care records we reviewed we saw evidence people's dependency was reviewed and updated on a monthly basis. This information was then used to determine appropriate staffing levels for the following month. The manager told us staffing levels were also reviewed following new admissions to the home and that there was also the flexibility to review and amend staffing levels in response to changes in people's needs.

People, relatives and staff we spoke with felt there were generally sufficient staff to meet people's needs. During our visit we observed there were enough staff on duty to safely meet people's needs. We saw people with mobility difficulties were assisted safely and staff suitably assisted people who might be at risk when they were eating and drinking.

We asked the registered manager about vacancies and the use of agency staff as this had been raised as a concern with us prior to the inspection. The registered manager told us they currently had vacancies for a Deputy Manager and a Night Nurse and were also currently recruiting additional care workers. We were informed as a result of these vacancies and the difficulties the service had been experiencing in filling the vacancies that they had been using agency staff. The registered manager advised us the service had a relationship with an external agency and that continuity of care was achieved through the use of the same agency staff wherever possible. We were informed the service had recently recruited a Nurse to cover two night shifts a week and at the time of our inspection this staff member was receiving their induction. In

addition to this, the registered manager also informed us the service was holding a recruitment day in August 2016 to try and fill the remaining vacancies.

We reviewed the staff files for five staff members who had been recruited by the service in the last two years. We found potential staff members were asked to complete an application form which covered areas such as their previous experience and qualifications, a full employment history and details of two referees. Appropriate checks were undertaken with the Disclosure and Barring Service (DBS) to establish whether staff members had a criminal record. Two references had been sought in all of the files we reviewed; however, in two of these files we found a reference had not been requested from the person's previous employer as stipulated in the provider's policy and procedure. We highlighted this to the registered manager who said they would look into this. We also found people's right to work in the UK was checked, potential staff members were asked to complete a health questionnaire and the service had a system in place for checking professional registration.

In the files we reviewed, documentation indicated interviews were only being conducted by one member of staff, which contradicted the provider's policy and procedure. We highlighted this to the registered manager and the regional manager at the end of the first day of inspection. We were told interviews were always undertaken by two people. We were informed one person would ask the questions and another person would be present as a note taker. The registered manager and regional manager suggested this may not be clear from the documentation. On the second day of the inspection we observed interviews were taking place and these were conducted by two members of staff.

We looked at the management of medication. We were informed the service had recently adopted a new, electronic system. We observed the use of this system during a medication round completed by one of the nurses. The nurse used a hand held device to open up medication administration records for each person they administered medication to. These records included a picture of the person to help ensure medication was given to the correct person. Medication due to be administered was highlighted on the hand held device. The Nurse scanned the medication, administered it and then recorded the administration on the device. Errors or alerts were automatically identified. For example we observed there was an insufficient therapeutic gap between administrations; this was identified by the device. We observed the nurse took appropriate action in response to this, returning to administer the medication to the person at the end of the medication round once there had been a sufficient therapeutic gap. During the medication round we observed the nurse followed good hand hygiene practice. We also observed the nurse asking people for their consent prior to administering their medication.

Prior to the inspection we were made aware of concerns about how the service managed the administration of covert medication, which is medication administered to a person without their knowledge. As a result of these concerns we looked at the care records for one person using the service who received their medication covertly. We saw this person had a care plan in place for the administration of covert medication which had been updated on 8 July 2016. This provided specific guidance to staff on how to administer the person's medication.

The service had a medication policy and procedure in place which had been updated to reflect the introduction of the new electronic system. This policy and procedure stated staff members who administered medication should have their competency checked on a yearly basis. Records we reviewed confirmed this had been done and there were no highlighted areas of concern. The service had two medication storage rooms, one on each floor. Both of these contained a medication fridge. We found the temperature of both rooms and fridges were regularly monitored and recorded and records indicated these were within safe ranges.

Requires Improvement

Is the service effective?

Our findings

People told us they felt they received an effective service from staff who knew what they were doing. Although some of the relatives we spoke with raised concerns about a high turnover of junior staff they indicated the service had a relatively stable senior staff team. People told us they were able to get assistance, stating; "It's never a problem." People and their relatives were largely positive about the food they received and told us they were always able to access drinks. People also told us the GP visited the home and that if they needed to see a GP this would be arranged for them.

New staff received an induction before starting work with people. As part of this induction, staff were provided with the opportunity to get to know people using the service, familiarise themselves with policies and procedures and shadow experienced members of staff. Prior to being allowed to provide care to people unsupervised, staff also had to successfully complete moving and handling training.

Staff members we spoke with confirmed they had received an induction when they first commenced their employment and told us they received regular training. However, when we examined the staff training records we found significant gaps in the training matrix. At the time of the inspection, overall compliance with training was at 71%. For example, 12 of the 29 staff members employed by the service were not up to date with basic life support training; 14 were not up to date with infection prevention and control training; 10 were not up to date with moving and positioning of persons including bed rails and 10 were not up to date with safeguarding. We found staff had not been given the on-going training they needed to keep their knowledge up to date.

We discussed this with the registered manager who told us deficiencies in the training programme had already been identified as an area for improvement. The registered manager informed us action had been taken to arrange appropriate courses throughout the rest of the year. Following the inspection the registered manager sent us details of the training courses scheduled to take place over the following three months. This confirmed staff were due to undertake training in the following areas; safeguarding, mental capacity, infection control, food safety and allergy, basic life support, moving and positioning, dementia awareness and challenging behaviour.

We asked the registered manager whether new staff members were being enrolled to complete the Care Certificate, which is a standardised approach to training for new staff working in health and social care which was introduced in April 2015. We were informed the service had all the necessary documentation in place for this but that as a result of staff shortages they did not currently have the resource to support this. The registered manager did however tell us that as an interim measure any new staff members who did not already have their NVQ Level 2, now known as a Health and Social Care diploma, were being enrolled onto this. Staff members we spoke with confirmed this.

The provider's policy for supporting staff included a commitment to providing four supervisions and an annual appraisal each year. Staff records we reviewed contained supervision records. Supervision meetings covered instances of both good and poor practice, training and development needs and reminders of best

practice and expected standards, for example in relation to the completion of food and fluid charts. Records we reviewed indicated the majority of staff received supervision meetings on a frequent basis, in line with the provider's policy, and staff we spoke with confirmed this. However, we found not all staff members had received their annual appraisal. We spoke with the registered manager about this, who confirmed she was currently completing these for all staff members. The registered manager told us that she had only completed annual appraisals for 10 members of staff since January 2016 and she still had approximately 20 to complete. Although the registered manager had an annual appraisal planner with dates scheduled for the completion of the remaining annual appraisals she acknowledged some of these staff member had not received an appraisal in over a year. We found staff had not been given the necessary support, in terms of annual appraisals, to perform their roles.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty so that they can 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.

We reviewed the records the service kept of DoLS applications. We found these were being made to the relevant local authority where deemed appropriate. We saw evidence these were monitored and action taken to update these on an annual basis as required.

The care plans we viewed showed a person's mental capacity was assessed when they joined the service. However, we found inconsistencies in the way this process was undertaken. We saw evidence the provider was aware of people's right to make advance decisions. However records in relation to this were poor. For example in one of the records we reviewed the admission assessment indicated the person had a relative who held lasting power of attorney or LPA (LPA is a legal tool that allows the person or the courts to appoint someone to make certain decisions on a person's behalf). However no documentation was held within the person's records in connection with this. In other records we saw evidence a relative had signed some documents on the person's behalf despite the person being assessed as having capacity.

In two of the care records we reviewed we saw evidence a signature had been obtained from a person or their relative in relation to their care plans. However this signature was recorded on the person's care plan summary sheet which simply listed each of the care plans in the person's care record. There was no date recorded against the signature in either of these care records and we noted the dates of the individual care plans recorded on the sheet differed. As such, it was not clear when the person or their relative had signed this document or which care plans this had been in relation to. We saw other examples of where people had signed their consent to actions such as the taking of their photograph for identification purposes, but not to their personal care.

During the inspection we became aware a person using the service had been escorted to their bedroom following an episode of challenging behaviour. We were informed by staff this was deemed to be in the

person's best interests in order to avoid harm. We observed the person was in bed with the bed rails in situ. As this could be deemed a form of restraint we asked to see the person's care records. These indicated the person had been assessed as lacking capacity to make decisions about their care and treatment. However we could find no evidence within the person's care records of a best interest decision in relation to the use of bed rails following an episode of challenging behaviour. We highlighted this to the registered manager and requested they review the person's care plan and liaise with the local authority.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with were aware of the need to gain people's consent prior to providing care or treatment. Staff told us they would explain what they were going to do before providing care or treatment to a person and that they would respect their wishes if they declined care or treatment. We saw evidence of staff seeking permission from people prior to providing them with care during the inspection.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk or malnutrition. We saw evidence where a risk was identified a care plan was implemented in order to manage this risk. For example, we reviewed the care plan for one person using the service who had been identified as being at risk of malnutrition. We found their care plan documented the support they required, details of their preferences in relation to eating and details of their supplementary diet. We saw input had been requested from the dietician and regular checks were completed of the person's intake and weight.

In the records we reviewed we saw where appropriate, choking risk assessments, food and fluid intake records and weight charts were in place. We saw evidence food and fluid intake was recorded accurately and concerns in relation to people's intake was highlighted during shift handovers. We also saw evidence people's weight was being monitored on at least a monthly basis and referrals were being made to relevant health care professionals, such as GPs, dieticians and speech and language therapists.

We spoke with the catering staff who confirmed they were made aware of any special dietary needs as well as people's preferences. We saw where people had a soft or pureed diet; special plates were used to separate the constituent parts. People we spoke with told us they had a choice of food and we observed people being offered a choice during our mealtime observations.

People we spoke with told us they were generally happy with the food they received although one person did comment that is was "on and off." One relative told us there was a "good variety of food" and another described how the service catered for their family member's special diet. Another relative told us their family member didn't eat much during mealtimes but that staff would make sandwiches especially for them and encourage them to eat these.

People's care records showed details of appointments with and visits by health and social care professionals. We saw evidence that staff had worked with various agencies and made sure people accessed other services in the event of an emergency or following a change in their needs. For example in one of the care records we reviewed we saw evidence the person had been referred to the dietician after losing weight. In another care record we saw evidence advice had been sought from the falls team after the person had suffered a number of falls over a short period of time.

We were informed a nurse specialist for older people and a GP attended the home on a weekly basis to perform a 'ward round'. As part of this process relevant information was provided to the nurse and GP by

staff within the home. One of the healthcare professionals we contacted about the service told us they felt the service generally made appropriate referrals and that staff acted on advice given. We saw evidence plans were updated to reflect the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various health and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People spoke very highly of the caring nature of the staff who supported them. Comments included; "Everybody's very nice here," "Very kind," "No matter what you ask, they do it" and one person described the service as a "home from home." One relative told us "I can't praise the staff enough." People and their relatives told us they were involved in their care planning and people confirmed they were happy with the care they received; with one person saying it "couldn't be better."

We noted a warm, inclusive atmosphere in the home. We observed staff were polite, friendly, patient and caring in their approach to people and their relatives. We observed staff carried out their tasks in an unhurried manner. Relationships between staff and people in the home were clearly based on mutual respect and affection. Staff and people appeared at ease in each other's company and smiled and chatted freely.

During the inspection we observed staff supervised people in the communal areas and in their bedrooms, and kept checks on people who might wander and come to harm. We saw staff responded quickly to people's needs and were attentive and caring in their approach to people.

Care records we reviewed contained a social/leisure needs assessment which captured details of people's life history including their family relationships, work history, interests and details of any spiritual or religious needs. People's preferred name and details of their next of kin and relevant healthcare professionals were also captured. In addition to this, specific preferences in areas such as people's night time routine and meal times were also detailed. People we spoke with felt the staff knew them quite well. Staff we spoke with seemed knowledgeable about the people they supported and were able to tell us information about their life histories as well as their likes and dislikes.

A guide to the service was provided to people that informed them about what they could expect from living at the home. A range of information was also displayed for people and their relatives to refer to. This included details of how to make a complaint, details of social activities, dates of the next resident and relatives meetings and copies of the latest survey results.

People and their relatives all told us they were consulted about their care and treatment and staff we spoke with confirmed this. We also saw evidence of the use of advocacy services in one of the care records we reviewed.

We observed routines in the home were flexible and people and their relatives told us they were able to make everyday choices such as when to get up and go to bed. One relative told us their relative could go to bed when they wanted and stated; "they can watch TV till 11pm and then go to bed."

The service had an activities co-ordinator and details of the activities programme was displayed on notice boards in the home. The activities coordinator explained how they would meet with people when they first joined the service to obtain information in connection with their likes and dislikes to assist them in

designing the activities programme. During the inspection we observed a number of activities taking place which people engaged in willingly. People we spoke with were positive about the activities programme and one person told us "Everyone does whatever they want."

Staff we spoke with were aware of the need to involve people in their care and we observed people being offered choice throughout the inspection. Care records we reviewed provided information to staff about areas where people required assistance. For example one record advised staff of the need to "communicate slowly" with one person to aide them in making their own decisions.

Staff we spoke with were also aware of the need to maintain people's privacy and dignity and were able to give examples of how they would do this, for example through closing the door when providing personal care. During the inspection we observed good practice, for example we saw staff knocking on people's bedroom doors prior to entering. During mealtimes, where people required assistance to eat we observed this was done in a sensitive manner. We observed a staff member sat with the person throughout the meal and engaged with them on a one to one basis.

Requires Improvement

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One relative explained how their family member really enjoyed cups of tea and that in order to cater for this staff would serve them tea in an extra-large mug, which their relative loved. People we spoke with told us they were happy with the service; "never had a complaint," and "no, no complaints" but that if they were unhappy about anything they would feel able to raise this.

In the care records we reviewed we observed that a pre-admission assessment was completed. We found this covered areas such as personal details, any known allergies, medical history, details of any relevant healthcare professionals involved in the person's care as well as a high level overview of areas where the person required support, for example with mobility. In the care records we reviewed we found not all sections of the pre-admission assessment had been completed and that in some people's records the dates recorded on the different sections of the assessment were different. We discussed this with the registered manager who informed us these assessments had been archived in error for some people using the service. As a result the service had recently undertaken work to complete new records for these people and this was why the dates were different.

When a person joined the service we saw evidence a full admission assessment was completed. Information gathered during this assessment and the pre-admission assessment was used to draw up care plans for areas where a person was assessed as requiring assistance. Care plans provided guidance to staff on the level of assistance a person required. We found evidence people were encouraged to maintain their independence as far as possible. For example in one of the care records we reviewed we found the person had been identified as being at risk of falls however they were still encouraged to mobilise themselves with staff being advised; "[name] has a history of falls. Staff to observe [name] during the day."

Staff we spoke with confirmed people's care plans were available for them to review prior to supporting someone and that they provided them with the information they required to meet people's needs. We saw evidence care plans were evaluated on a monthly basis to ensure they remained accurate. We were advised reviews were generally completed on a six monthly basis or where there had been a change in a person's needs and we saw evidence of this in the records we reviewed. For example we saw the use of bed rails was causing one person using the service distress. As a result of this, a full review was completed involving the person and their family members and action was taken to remove the bed rails, reposition the person's bed and introduce a sensor mat instead.

In the care records we reviewed we found it was not always clearly recorded whether people had been involved in their care planning. However, people and relatives we spoke with confirmed they were regularly involved. Staff we spoke with also confirmed this and one of the senior carers we spoke with explained how they would sit with people and their relatives when completing six monthly reviews of people's care records.

The care plans in all of the care records we reviewed were recent. There was evidence these care plans were

being evaluated on a monthly basis and where appropriate updated to reflect changes in people's needs. One of the senior carers explained how they would review the daily notes on a monthly basis to determine whether any changes were required and where possible they would try to involve people and their relatives in this process. Relatives we spoke with felt they were kept up to date about their family members and one relative told us they could call anytime for an update and stated, "I can talk to anyone."

During the inspection we observed staff supervised people in the communal areas and in their bedrooms, and kept checks on people who might wander and come to harm. We saw staff responded quickly to people's needs and were attention and caring in their approach to people.

We reviewed the provider's complaints file. We found a total of six complaints had been recorded in the last 12 months. We found the records held in relation to complaints were very limited and consisted largely of a 'concerns and complaints' register. This provided a brief overview of the complaint, including who raised it, when and a summary of action taken. The file also contained copies of correspondence issued in connection with these complaints. However in five of the six complaints we reviewed we found no evidence of an internal investigation and although there was evidence of correspondence with complainants these were often incomplete. In addition to this, during the inspection one relative informed us they had complained twice, once verbally and another time in writing about an issue their relative had experienced. The relative explained the most recent complaint had been made approximately three months ago but that they had still not been informed of the outcome. After reviewing the complaints record we found these indicated the complainant had been informed of the action taken and was satisfied with the outcome. We highlighted this to the registered manager who advised they would discuss this with the relative.

When reviewing the complaints file, we found two complaints, one received in January 2016 and another received in April 2016 should have been dealt with as safeguarding incidents rather than complaints. These related to an incident of alleged financial abuse and a potential medication error. We discussed these with the registered manager who confirmed they would look into this and provide us with an update.

Following the inspection the registered manager sent us confirmation that the allegation of financial abuse had been referred to the safeguarding adults' team within the local authority and had also been investigated by the Police. The registered manager informed us the incident regarding a potential medication error was still under investigation. However there was no indication whether consideration had been given to referring this incident to the local authority safeguarding adult's team and there was no evidence an internal investigation had been undertaken in relation to either of these complaints. We reminded the registered manager of their responsibilities under the Health and Social Care Act 2008 and also referred them to the ADASS (Association of Directors of Social Services) safeguarding threshold guidance.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We reviewed the copy of the latest feedback summary report which we were informed was from questionnaires which had been issued to people, relatives and staff in April 2016. We found results had been obtained from five people using the service, 22 visitors and 23 staff members. The service received largely positive responses throughout. Those surveyed felt the home was clean, people were safe and staff were available for people when they needed them. People who responded also felt the home was welcoming and inviting and that people's comments, concerns or complaints were listened to. We noted that there was no information recorded about the action the service planned to take in response to the few areas where negative comments had been received. We discussed this with the registered manager who informed us the survey results had only just been received by the home and that as such they had not yet had time to do this.

People and relatives we spoke with felt they were regularly asked for their views on the service and that the service was responsive to their comments. One relative told us there were feedback forms available on reception and that they had previously been sent these in the post as well. People also told us that they were able to attend meetings to share their opinions of the service. A review of the service's meeting folder confirmed residents and family meetings was offered on a bi-monthly basis. We saw from the records these were not very well attended and that the registered manager had tried changing the time and date of these in the past in an attempt to increase attendance. During the inspection we observed notices were on display in the home advertising the date and time of the next meeting and that feedback forms were available on reception.

Requires Improvement

Is the service well-led?

Our findings

People told us they felt the service was well led. People and their relatives felt they were asked for their views about the service and these were listened to. They also said they felt the registered manager was approachable and they would have no concerns approaching her if they needed to. Staff spoke highly of the company and of the registered manager in general; "It's a nice home, the company's spot on." One of the ancillary staff members we spoke with also commented that they felt it was good they were offered the same training opportunities as the care staff. They went on to explain this meant they could assist during emergencies, for example if they needed to evacuate the service. One of the external healthcare professionals we contacted commented: "I think that Wallace House is very well managed and the care and respect they have for the people who live there is evident."

Although the registered manager had only been in post since the start of 2016 and had only registered with the Care Quality Commission in May 2016, she had worked at the service for approximately three years. Staff spoke highly of the registered manager and told us she would often come round to check on staff and people using the service. We saw evidence of this during the inspection.

The registered manager informed us they were currently recruiting for a Deputy Manager and a Night Nurse but that at present they were supported in their role by the Regional Manager, the two day Nurses and the senior carers. The registered manager had delegated responsibility in some areas to other staff members to assist in the effective running of the service.

Records we reviewed indicated nurse and senior meetings and staff meetings were held on a bi-monthly basis. We found there was a clear record of the topics discussed during these meetings and evidence that areas for improvement as well as good work were fed back to staff. Areas covered during meetings included; feedback from commissioning visits, record keeping, training, supervision and appraisal as well as sickness and the use of agency staff. We found topics were covered in adequate detail and informed staff of expected standards of work. Staff we spoke with felt they received an appropriate level of support from the manager and the provider as a whole and that they were kept up to date with changes that affected them.

The registered manager advised us that they had an open door policy and that staff, people or their relatives were able to speak to them at any time. Staff we spoke with confirmed this and told us they felt the registered manager was approachable and they would feel comfortable raising concerns with her. People and relatives we spoke with also felt the service was well managed and that they were able to raise concerns freely with the registered manager and other staff members.

During the inspection we asked to review the provider's accident and incident policy and procedure and associated records. The policy and procedure stated a monthly analysis would be completed of falls to assist the service in determining whether referral to an external professional was required. We found copies of entries from the home's accident record book were kept in date order but could only find an analysis of these from March 2016. We highlighted this to the registered manager who confirmed this was the only month in which an analysis of these had been completed during 2016. Although further scrutiny of the

records for two people who had suffered a number of falls in June 2016 appeared to indicate appropriate action had been taken this was not clear from the records held within the accidents and incidents folder. We found similar problems when reviewing the records held in relation to safeguarding incidents.

The provider had a range of systems in place for checking the quality of the service. These included regular audits of areas such as medication, catering, infection control and prevention and hand hygiene. Quarterly monitoring visits were also completed by the regional manager. We saw evidence that issues or areas for improvement identified during audits were carried forward and action taken to resolve these. However, we found this was not always effective and that records documenting this were poor. For example we found an internal quality monitoring audit had identified that monthly checks were not being completed of Nurses pins. We reviewed the home's development plan, which indicated action had been taken in January 2016 to address this. However when we reviewed the folder containing these checks we found checks had not been completed in March or April 2016. In addition to this we found staff not removing toiletries from the edge of the communal baths within the home had been consistently identified as an area for improvement identified during the monthly infection control audits. However during the inspection we found this was still an issue.

We also found the service did not have a consistent approach for documenting issues and areas for improvement or the action taken to address these. For example we found some of the audits we reviewed contained an action plan. In some cases, for example with the infection control audits completed in 2016, we found this had been completed with the issues or areas for improvement identified during the audit. In other cases this action plan had not been completed but areas for improvement or issues had been captured on the home's development plan. Where action plans had been completed there was no evidence these had been updated to reflect actions taken to resolve the issues. As a result it was difficult to determine whether effective action was being taken to address issues or areas for improvement which had been identified.

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

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured people's care and treatment was given with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Effective systems were not in place for identifying, receiving, recording, handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had not been established to assess, monitor and improve the quality of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing

Treatment of disease, disorder or injury	The service had not ensured that staff had received appropriate support, training, personal development and appraisal.