European Healthcare Group PLC

Old Wall Cottage Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 and 10 July 2018. The first day of our inspection was unannounced. We informed the provider we would be returning to the service the following week but did not specify a day or time.

Old Wall Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Old Wall Cottage is a nursing home which accommodates up to 33 people in one adapted building. The building is divided into two units. There were 26 people living at Old Wall Cottage at the time of our inspection.

There was no registered manager in post. 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 last registered manager left Old Wall Cottage in October 2017. Since this time the service has been managed by an existing staff member (acting manager) with support from the regional management team.

Sufficient staff were not deployed to meet people's needs. People were left waiting for their care on occasions and there were not always sufficient staff present in communal areas to monitor people's safety. Staff employed did not always receive the training they required to meet people's needs. Clinical staff training had not been regularly updated although a programme of training had been organised. Staff had not always received regular supervision although systems to ensure this took place had been implemented.

Risks to people's safety were not always adequately monitored and records of risk monitoring were not accurately maintained. People did not always have access to a call bell in order to summon assistance when required. Infection control practices were not monitored and some areas of the service were not clean. Medicines were not always managed safely. The temperature of medicines storage was higher than recommended limits and action had not been taken to minimise this risk. People had not always received their medicines in accordance with prescription guidelines and topical creams were not appropriately managed.

Quality assurance processes were not always effective in ensuring that any shortfalls in the care people received were identified and acted upon. Although staff told us they felt supported in their roles, there was a lack of management oversight and the values of the service were not consistently upheld. Complaints were responded to although were not reviewed to ensure they did not happen again. We have made a recommendation regarding this.

People's legal rights were not always respected as the principles of the Mental Capacity Act 2015 were not always followed. People's capacity to make specific decisions was not always assessed and restrictions in

place were not always discussed to ensure they were in people's best interests. People were not always treated with dignity as elements of people's personal care were not always attended to. People's care was not always personalised as people's preferences and past lives were not always taken into account. Care plans regarding the care people wanted when reaching the end of their lives lacked detail. There was a lack of activities for people to be involved in. We have made a recommendation regarding how people were supported with food choices although people's nutritional needs were met.

In other aspects of people's care staff demonstrated a caring approach and responded to people's needs positively. People were supported to maintain their independence and interacted positively with people. Visitors were made to feel welcome and there were no restrictions on visiting times. People and their relatives were involved in the care planning process and any guidance from relatives was listened to. Regular resident and relative's meetings were held and feedback gained was positive.

People were assessed prior to them moving in so the service could be sure they were able to meet their needs. People were supported to remain healthy and had access to a range of healthcare professionals. The environment was suitable for people's needs and aids and adaptations were available.

Staff understood their responsibilities in safeguarding people and protecting them from potential abuse. Safe recruitment processes were in place to ensure that staff employed were suitable to work at the service. Accidents and incidents were recorded, reviewed and action taken to minimise the risk of them reoccurring. Regular health and safety checks were completed and equipment was serviced to check it remained safe for use.

During this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated) Regulations 2014. 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?

Requires Improvement

The service was not always safe.

Sufficient staff were not deployed to meet people's needs.

Medicines were not always stored and administered safely.

Risks to people's safety and well-being were not consistently monitored.

Safeguarding processes were known to staff and concerns were appropriately reported.

Safe recruitment practices were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2015 were not followed and people had not always consented to their care.

Staff training and supervision was not consistently updated to ensure staff had the knowledge they required with their role.

People were provided with a choice of nutritious food although people's preferences were not always taken into account. We have made a recommendation regarding this.

People's health was monitored and referrals made to external healthcare professionals when required.

People lived in an environment which was suitable for their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and their privacy was not always respected.

Staff spoke to people with kindness and interactions were positive.
People were supported to develop their independence and their cultural needs were respected.

There were no restrictions in place regarding visiting times.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of person centred activities for people to be involved in.

Care plans were not always updated and people's preferences were not always taken into account.

The care people wanted at the end of their life was not always recorded or known to staff.

Complaints addressed although not always recorded appropriately. We have made a recommendation regarding this.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in post.

Quality assurance systems were not always effective in identifying areas requiring improvement.

The values and ethos of the service were not embedded into practice.

Staff felt supported in their roles.

People and their relatives were able to share their views of the service and suggestions were acted upon.

Old Wall Cottage Care Home

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 5 and 10 July 2018. The first day of the inspection was unannounced. We informed the provider we would return for a second day the following week but did not indicate the day or time. We arrived for the second day of the inspection at 7am as we had found concerns regarding how people's personal care was provided. The inspection was carried out by two inspectors and a nurse specialist who specialised in the care of older people.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we had not asked the provider to complete a Provider Information Return (PIR) within the last 12 months. The PIR 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.

During our inspection we observed the care people received and spoke with the acting manager, the regional care manager and nine members of staff. We spoke with four people living at Old Wall Cottage and four relatives.

We reviewed a range of documents about people's care and how the home was managed. We looked at 10 care plans, four staff files, medicines administration records, risk assessments, accident and incident records, complaints records, policies and procedures and internal audits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Old Wall Cottage. One person told us, "There are staff here to help, not like at home." One relative told us, "We looked at lots of places before we chose here and then we visited six times to make sure it was right for (family member). The staff are always friendly." Another relative told us, "(Senior staff) are always around and checking everything which I find very reassuring. Dad's at risk of falling and they check him every hour at night. They're very aware of everything." Despite these comments we found that people were not always receiving safe care.

Sufficient staff were not always appropriately deployed to meet people's needs safely and in line with known risks. Senior staff told us that there were four care staff and one nurse working during the day. There were two separate areas of the service which meant two care staff were assigned to each of the areas. Care records identified that a number of people required close supervision from staff due to being at high risk of falls. However, people were regularly observed to be seated in the lounge with no staff present to assist them should they require support. This was particularly evident in the morning when staff were busy supporting people with their personal care. This meant that there was an increased risk to people's safety. Staff did not always have time to spend with people socially. Although staff showed kindness towards people they were constantly busy completing tasks which meant they did not always get time to spend meaningful time with people. One staff member told us, "We need to get the staffing levels now so we can spend the right time with our clients."

On the first day of our inspection people were waiting for lengthy periods for staff to support them to get out of bed and ready for the day. Three people who had been awake when we arrived in the morning did not receive their morning care until lunchtime. On the second day of the inspection we observed people were supported in a more timely manner. However, this was due to the acting manager and nurse supporting people in addition to the care staff. At lunchtime we observed some people had finished their main meal and pudding whilst others were still waiting for staff to support them with their lunch. During the inspection we also found concerns regarding the monitoring of risks and records relating to people's care. The acting manager and senior nurse told us they found it difficult to monitor this due to the number of demands on their time. They told us they found it difficult to manage their time as they regularly had to support care staff in providing people's day to day care. We discussed these concerns with the group care manager and acting manager who acknowledged that staffing levels within the services needed to be re-assessed, especially in light of the acting manager's responsibilities increasing.

Failing to ensure that sufficient staff were deployed in the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe medicines practices were not always followed which meant people were at risk of not receiving their medicines in line with relevant guidelines. Each person had a medicine administration record (MAR) which was signed by staff following each administration. However, we found discrepancies in three people's medicines as more tablets were in stock than were recorded. This meant that despite staff recording these medicines had been administered, the people concerned had missed a dose of their prescribed medicines.

On the second day of our inspection we were shown evidence that these discrepancies had been discussed with the GP to ensure there was no impact to the people concerned. MAR charts were not always completed in line with good practice guidelines. Where entries of medicines were handwritten, these had not been signed by two staff members to ensure they had been transcribed correctly and minimise the risk of errors.

Safe procedures had not been followed for one person who received their medicines covertly (without their knowledge or consent). Records showed that the person's GP had been involved in the decision to administer the persons medicines in this manner. Staff told us the person's medicines were disguised in their food. When administering medicines covertly involvement from a pharmacist is required to advise on the suitable foods or drinks that may or may not be used for each medicine as some foods may decrease the absorption of some medicines. There was no evidence within the persons records to show that the pharmacist had been consulted.

Topical creams were not always dated when opened to ensure they continued to be safe to use. Where creams had been dated these were not always disposed of following the recommended 28-day period. One person had three containers of the same topical cream in their room. All had been opened and showed dates going back to April 2018. On the second day of our inspection action had been taken to dispose of all creams which were beyond the recommended use by period. There were no cream charts or body maps in place to guide staff on how and when topical creams should be applied.

Medicines were not always safely stored. On the first day of our inspection we found the temperature of the fridge and the room where medicines were stored was above safe limits for medicines to be stored. The acting manager placed a fan in the room and left the door to the area open when it was safe to do so. Despite these actions we found the room temperature was still above recommended levels on the second day of our inspection. The area manager reassured us that they had been in contact with the pharmacy regarding these concerns and had ordered a more substantial cooling system for the room.

Other elements of medicines management were safely managed. Medicines were stored securely and keys were only available to trained staff. Where people required 'as and when required' medicines (PRN), guidance was available to show when and how these should be administered. A policy was in place regarding the administration of homely remedies and we found this had been followed by staff.

Risks to people's safety and well-being were not always reviewed and monitored. Risk assessments for areas including falls, skin integrity, malnutrition and de-hydration had been completed. However, guidance for staff in how any identified risks could be reduced was not always effectively monitored. Where people were assessed as being at high risk of pressure sores air mattresses were provided to reduce this risk. There was no system in place to ensure that air mattresses were at the correct setting for the person's weight and that the air mattress continued to work properly. We reviewed people's weights and mattress settings and found that these had been incorrectly set for five people. In addition, two people were using air mattresses at different settings when their weight was not known to staff. Air mattress checks were not regularly monitored to ensure that they remained in good working order and at the correct setting. The last check had been completed in March 2018. Care records for two people stated they required support to reposition every two to four hours. The people concerned did not receive this support during our inspection. The handover sheet which staff referred to, stated no one required this support.

Where people required their fluid intake to be monitored records were not accurately maintained or reviewed. Records of the fluid intake and output of people with catheters showed large variances which had not been investigated. There were no fluid intake targets set for people at risk of dehydration. Charts showed some people were consuming very low levels of fluids. However, there was no system in place for

amounts to be totalled in order that low levels could be identified and acted upon. We did however observe that people were offered regular drinks throughout the day.

The acting manager and senior nurse acknowledged that identified risks required closer monitoring. They stated that they found this difficult to do due to time pressures within their job role. However, they stated they felt that risks were mitigated due to the majority of staff having worked at Old Wall Cottage for many years and knowing the people they supported very well. They told us that staff were experienced in identifying and reporting any changes in people's health. People's records confirmed this was the case and showed overall low levels of infections, pressure sores and significant weight loss.

People did not always have access to call bells in order to summon assistance. The majority of people living at Old Wall Cottage were unable to summon assistance using a call bell due to their health needs. However, we viewed three people's care records which stated they should have their call bell close to them. On the first day of inspection we noted that during the morning only one of the three people had their call bell within reach. We spoke to one person who told us they were unsure of what was happening that day and would like some assistance from a member of staff. The person was able to use a call bell but this was placed on the wall out of reach. We informed the acting manager of the person's request for support. When the person returned to their room in the afternoon we noted that staff had ensured their call bell was next to them. On the second day of inspection we found that this concern had been addressed throughout the service and where appropriate call bells were within reach. We observed that staff responded promptly to answer call bells.

Safe infection control practices were not always followed. We found some areas of the service were not cleaned to a satisfactory standard. On the first day of our inspection we found a number of chairs were ingrained with dirt and some surfaces were sticky. The stand-aid hoist had food debris on the foot plates which had caused the edges to become rusty. The washable fabric on some bed bumpers was worn which meant germs could be harboured. The group care manager and acting manager told us that they had experienced difficulties in recruiting additional housekeeping staff which they felt had contributed to these concerns. They gave assurances that they would address the issues raised. On the second day of our inspection we found that a deep clean of all areas was underway. All areas of the service looked and smelt fresher. The group care manager assured us that new chairs had been ordered and a review of bed bumpers was being completed. We will check the effectiveness of these measures during our next inspection.

The failure to monitor risks to people, to manage medicines safely and to ensure safe infection control procedures was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff followed guidance regarding infection control processes in other areas. Gloves and aprons were available and staff were seen to use these when supporting people. The laundry area was organised to ensure that clean items did not come into contact with soiled laundry. Staff we spoke to were aware of the correct procedures and temperatures for dealing with soiled items.

Accidents and incidents were recorded and analysed to identify any trends. Accident and incident forms were completed by staff and the acting manager made aware of any concerns. This ensured that any immediate action was taken to keep people safe. Forms completed referred to falls, behaviours and minor accidents. Records showed that where required people were referred to their GP or other services for support and additional monitoring equipment was provided where required. A review of accident and incident forms was then completed by the regional team to ensure that no further action was required and to monitor for any trends or themes.

Staff were aware of their responsibilities in reporting safeguarding concerns. Staff we spoke to were able to identify the different categories of abuse and describe the signs they should look for. Staff understood how to report any concerns and information was displayed within the service to prompt them as to where information could be accessed. One staff member told us, "The residents are like our family. None of us would see anything bad happen and not report it." Records showed that concerns were shared with the local authority and any advice provided was followed.

Safe recruitment procedures were in place to ensure staff employed were suitable to work in this type of service. All staff files contained appropriate checks, such as an application form, evidence of a face to face interview, two references and a Disclosure and Barring Service (DBS) check. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Checks were completed to confirm that nurses' professional registrations were in date.

Regular safety checks and servicing of equipment was completed to ensure it remained suitable for use, with the exception of air flow mattresses. This included moving and handling equipment, gas safety, water safety and fire equipment. The provider had a contingency plan in place which guided staff on the action they should take in the event of an emergency. This included how people should be supported to access alternative accommodation should the building not be available for use. Each person had a personal emergency evacuation plan which highlighted the support they would require from staff and the emergency services to evacuate the premises. Fire drills had been completed and reports of any learning shared with staff.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive the training they required to support them in their roles. A training matrix was maintained which highlighted when staff had last completed elements of their training and when refreshers were next due. The matrix highlighted gaps in training in areas including safeguarding, mental capacity, first aid, dementia awareness and health and safety. We found areas where staff's lack of training and understanding impacted on the care people received. For example, staff were unable to demonstrate how the Mental Capacity Act influenced their role and what measures they should take to ensure people's rights were protected. We also identified long gaps in clinical staff training. A visiting healthcare professional told us they believed clinical staff would benefit from updated training in areas such as wound care and catheter management. As a consequence of clinical staff not having up to date training in all relevant areas, the district nursing team were required to provide additional support to the service. The group care manager provided evidence that they had begun to address training for clinical staff and dates had been booked for updates.

Systems for staff supervision and support were not embedded into practice. Recent records for the service showed that staff had received supervision in line with the provider's policy. However, prior to this three-month cycle stated in the providers policy, gaps in staff supervisions were noted. Clinical staff also received supervision although this was not used as an opportunity to review their clinical skills and address any areas where additional support and training may be required.

The failure to ensure staff received effective training and supervision to support them in their roles was a breach of Regulation 18 of the Health and Social Care Act 2008 (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 people 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

People's rights were not always protected as the principles of the MCA were not consistently followed. Care records showed that capacity assessments were not always completed for specific decisions such as covert medicines, use of bed rails and key padded doors. Care records viewed contained care plans regarding people's mental capacity and cognition. These included statements which indicated people did not have the capacity to make simple decisions. However, there was no specific decisions listed to demonstrate how this may impact on people's care. Best interest decisions were not consistently recorded to determine if measures taken were the least restrictive options, how decisions had been reached, who had been involved or any previous wishes of the person concerned.

DoLS applications had been forwarded to the local authority where restrictions to people's freedoms were

in place. However, the applications did give not give a comprehensive view of the restrictions people were subjected to. This meant that the local authority did not have the information they required in order to prioritise applications.

The failure to ensure the principles of the MCA were followed in order to ensure people's rights were protected was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with nutritious food although consideration was not always given to people's preferences or how their meals were presented. Where people required a soft or pureed diet, a choice of meal was not always provided. In addition, we were informed on the first day of our inspection that gravy was poured onto all soft and pureed meals. This included fish and dairy items. The catering staff confirmed this was to ensure the food was of a suitable consistency to minimise the risk of choking. Consideration had not been given to how different preparation methods or a range of sauces could be used to ensure people's food was safe and appetising. It was also noted that when offering people a drink in the afternoon there was no coffee available on the drinks trolley and this was not given as an option to people. We asked one person if they liked coffee. They replied, "Oh I do but I always forget to ask for it." Staff confirmed that the person's relative brought them a take away coffee when they visited. We viewed records for one person which listed one of their preferred drinks as coffee. We discussed our concerns with the group care manager. On the second day of our inspection we found that people were offered a choice of coffee. We were also assured that suitable alternatives to gravy had been discussed and would be used going forward.

We recommend that systems to monitor the choices of food and drinks provided to people are implemented and regularly reviewed.

In other areas we found that people were offered choices and their preferences were catered for. People and their relatives told us the food provided was of a good standard. One person said, "Very good thank you, "Another person said, "I have enjoyed it (lunch)." One relative told us, "The food is lovely, really good." Another relative told us their family member enjoyed salads. They had informed the catering staff of this and since this time they had been given a side salad with their meal every day. Choices of cold drinks were available to people and offered throughout the day. Staff were aware of people's dietary needs and ensured these were catered for. The catering team had a list of people's needs and were keen to ensure these were met. As indicated earlier in the report some people had to wait to be supported with their meal. However, when support was provided this was done in a caring manner and at a pace which suited each person. People's weight was monitored and action taken where significant variances were noted.

People were supported to access health care professionals where required. Relatives confirmed that people were supported to maintain good health and relevant professionals were involved. One relative told us, "They identified an issue early on and have been very good at going to hospital appointments with her." Another relative told us, "I'm in every day and they will say if there's anything wrong." We spoke with a visiting healthcare professional who told us that staff were responsive to people's health needs. They confirmed that staff made appropriate referrals for healthcare visits, ensured relevant information was available and that any advice given was followed. They added that the responsive action of clinical staff had led to a reduction in the number of antibiotics prescribed for infections. Care records contained information regarding professionals involved in people's care including district nurses, occupational therapists, speech and language therapists and chiropodists.

People's needs were assessed prior to them moving into the service to ensure they could be met. Relatives confirmed that they had been involved in the assessment process. One relative told us, "We went to a few

homes but this was the one where they seemed interested in him as an individual." Another relative said, "They didn't mind how many times we visited. They were fantastic and anything we asked for they just took on board." Assessment documents contained information regarding the person's health, their current support needs and additional information relevant to their care. We spoke with staff regarding people who had recently moved into Old Wall Cottage. They were familiar with the person and were able to tell us about how they were settling in and their family involvement. This information matched with the assessments completed.

People lived in an environment which was suitable for their needs. Accommodation was all on one level and we observed people were able to move freely around the service. Handrails were fitted to aid people's mobility. People's names and pictures were placed on their doors to help orientate them to their room. Seating provided was of an appropriate height and style and rise and recline chairs were available where required.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff were caring and kind. One person told us, "They're okay with me, we can have a smile and a giggle." One relative said, "Staff are very caring and welcoming. They look out for individual residents' needs. They're very personal and always show everyone respect." Another relative said, "It's more like a home than other places which we found were too big. Because it's small you're a person not a number. They all very friendly." A third relative told us, "We couldn't ask for better care for her. The staff are amazing with everyone."

Despite these comments were found that staff did not always treat people with dignity and their privacy was not always respected. During the first day of our inspection we found that a number of people's toothbrushes were dry and appeared not to have been used for some time. The people concerned had recently been supported with their morning personal care. One person who was in bed attracted the attention of a staff member as they were passing. The staff member went into the person's room, said good morning to them and removed their breakfast things. Shortly following this we went to speak to the person and found that they had porridge on their face, down their night clothes and over the bed. The staff member had not acknowledged this and no staff returned to support the person. After 20 minutes we shared our concerns with the acting manager who ensured the person was supported. Not all staff respected people's privacy. We observed staff entering people's rooms without knocking or asking the person's permission. On the second day of our inspection we found that action had been taken to address these concerns. People received their personal care promptly, toothbrushes appeared to have been used and staff were seen to knock on people's doors more frequently. We will check that these standards have been maintained during our next inspection.

The failure to ensure that people's dignity and privacy was respected at all times was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some staff did not treat people with respect, we saw other examples in which staff were respectful. We observed positive interactions between people and staff. Staff acknowledged people as they passed them, asking how they were or if they needed anything. When speaking with people in the lounge areas staff knelt beside them and made eye contact. Staff were seen to share jokes with people and to use appropriate touch to offer reassurance. One relative told us, "One of the things I like is that if you mention anything they already know and are on it. They know her so well."

People were supported to maintain their independence. One relative said of their family member, "In hospital he'd stopped feeding himself but staff have worked with him and he's doing it himself now. He's put on weight here." We observed that where required people had adapted crockery and cutlery to support them in eating independently. Another relative told us, "They keep her walking and moving. It's really important to her." Aids and adaptations were available to people to support them in mobilising and handrails were fitted throughout the service. One person had been assessed as being able to return to their own home with a package of care. The acting manager and staff were actively supporting the person to achieve this and had involved the local authority to ensure the person's needs were known when they

moved on.

People's religious and cultural needs were respected. The group care manager told us that the local minister visited each month and performed a service which people enjoyed. English was not one person's first language. Although they were able to understand English, where possible staff spoke to them in their first language which they responded to well.

People's rooms contained personal items. One relative told us, "It was important to me that her room was just right for her. They were so good at helping us and putting things on the wall. It's so lovely and peaceful for her there now." A number of people had sensory blankets placed on their beds. A staff member told us she had requested a friend make these for people to give them something to fiddle with. Sensory fiddle mitts were also placed around communal areas and one person was encouraged to use these to keep occupied.

Visitors told us they were made to feel welcome at the service and there were no restrictions on the times they could visit. One relative said, "I come in every day. You can come in as often as you like for as long as you like." Another relative said, "One of us is here every day. We can come and eat lunch with her which is really nice for all of us." We observed regular visitors to the service throughout the inspection. Staff welcomed them and ensured they were offered refreshments.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they felt the service was highly personalised. One relative said, "You only have to say anything once and they do it. I told them that Dad really feels the cold and asked if he could have another layer on. It's been done every day since." Another relative said, "The best thing is the atmosphere and friendliness. It's all personalised to (family member). I've come in the afternoons and found her laid on her bed listening to her classical music which she loves."

Despite these comments we found that the service did not always take people's personal wishes into account. One person's records repeatedly stated they did not like to sit in the lounge area and preferred the privacy of their own room. It described how the person would become vocal when in communal areas of the service. During the inspection we observed the person was taken to the lounge after their morning personal care and remained there throughout the day. We spoke to staff about this who told us the person's needs had changed and their health deteriorated. They told us they therefore brought the person into the lounge so they could, "keep an eye on them." This meant that the person's previous wishes had not been taken into account once they were unable to voice their preferences.

Two people living at Old Wall Cottage preferred to be called by a name other than their given Christian name. However, their Christian names were written on their doors and were the names used by the majority of staff when speaking with them. We asked one staff member why the people were not addressed by their preferred names. They told us, "I don't think they mind." The person told us they didn't see their given Christian name as their name and wanted to be called by their preferred name. Their care plan stated they did not like to be called by their Christian name and could become agitated when it was used. This meant that staff had failed to consider people's personal preferences when speaking with people. Staff were not always able to tell us information which was important to people such as their family circumstances, past occupations and hobbies. Care plans did not always contain detailed information regarding people's past lives and interests for staff to refer to and create conversation.

Care plans were not always comprehensive and were not always up dated when people's care needs changed. One person's needs had changed considerably following a period of ill health. We found their care plans did not fully reflect these changes to guide staff in providing their care. Whilst some care plans were in place with regards to specific conditions such as diabetes, guidance was not available to staff in other areas. For example, one person was diagnosed with epilepsy. There was no guidance for staff regarding the type of seizures the person may experience or what action they should take. People's wishes regarding the care they wanted when reaching the end of their life was not recorded in detail for staff to follow. Whilst basic information was available for some people such as if they would like to remain at the service and who staff should contact, other people had no information regarding their wishes recorded. This meant that people may not receive the care they would prefer at the end of their life.

People had little to do during the day and social activities were limited. One relative told us, "There's not much in the way of activities when I'm here but I think they have things in the afternoon." Another relative told us, "There could be more for people. They have just employed an activity lady so they are looking to

improve things." Another relative said, "They have music which is important to Dad and I've seen them do exercises and crafts." During the first day of our inspection we observed four people watching a film on a big screen in the morning. On the second day of our inspection a visiting activity person completed exercises to music which people appeared to enjoy. With these exceptions, no other activities were offered to people. On one wall of the lounge there were cotton tote bags with people's names on. The activity co-ordinator told us these were for use at weekends for one to one activities for people. We asked if these were offered to people during the week and were told other activities were available then. However, we did not observe this to be the case. People sat with little stimulation apart from the television which was very quiet in both lounges. The acting manager told us they had identified the lack of activities for people and an activities co-ordinator had recently been employed. They told us they were in the process of developing a more comprehensive programme of activities to participate in.

The failure to ensure people were consistently provided with person centred care and had access to a range of meaningful activities was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas we found that people's care was personalised and staff responded to their needs. On the first day of our inspection we met one person who had recently returned from hospital. The acting manager told us that they felt the person would benefit from moving to a larger room with a better outlook as they needed to spend more time in their room. On the second day of our inspection the person had moved rooms. They looked much brighter and were able to communicate and they were pleased with their new room. Another person who was living with dementia regularly spoke about needing to move on. The person had a small suitcase in their room which they could pack which helped to calm their anxieties. Another person indicated they enjoyed watching tennis. Their chair was placed close to the television and they spent time watching the Wimbledon Championship. Another person liked to have a newspaper every day and staff had arranged this for them.

Relatives told us they had been involved in their family members' care plans. One relative told us, "I'm in everyday if they want to check anything with me. They went through the care plan." Another relative said, "I sat and did the care plan with the nurse. They're very open to that here." Care records contained evidence that are plans were discussed with people and their relatives on an on-going basis.

Complaints were responded to although not consistently documented. A complaints policy was in place and displayed. A log of complaints was maintained which detailed the date, person and nature of complaint being made. However, records relevant to the concern were not easily accessible to show how the complaint had been responded to and if the complainant was happy with the outcome. The regional care manager was able to find some information to evidence this through a search of emails and other records. We asked the regional care manager how they monitored complaints to minimise the risk of them happening again when information was not easily accessible. They told us that as the number of complaints received was low this was not a concern.

We recommend that comprehensive records of complaints are maintained and reviewed.

Requires Improvement

Is the service well-led?

Our findings

When speaking to relatives regarding the management of the service they related this to the acting manager and senior nurse who had both worked at the service for many years. People and their relatives told us they felt the service was well run. One person told us, "They are nice and they're efficient." One relative told us, "They are always around, checking that everything is right and having a chat. They want to get things right for everyone." Another relative told us, "They are the absolute best. You'd never find nicer people."

Despite these comments we found that the service was not always well-led. There was no registered manager in post. The last registered manager had left the service in October 2017. A senior nurse stepped up into the role of acting manager and was being supported by regular visits from the group care manager and group regional manager. Whilst senior staff were able to demonstrate detailed knowledge of people's needs there was a lack of managerial oversight of the service. This meant that systems to monitor the quality of the service provided to people were not effective in identifying any shortfalls in the care people received. A new manager had been recruited to the service and following the inspection the provider informed us they had commenced their employment.

Quality management systems were not effectively used to identify shortfalls and drive improvement. A range of audits were completed on a monthly basis by senior and regional staff. These included audits of care plans, infection control, health and safety, accidents and incidents, medicines and nutrition. However, completed audits had not identified concerns found during our inspection. Infection control audits showed that no concerns regarding the cleanliness of the furniture and equipment had been identified. Medicines audits had not been effective in identifying that best practice was not being followed. Records designed to monitor risks to people's safety such as food and fluid charts and air mattress checks were not reviewed in order to ensure they were effective in identifying any concerns.

We spoke with the regional care manager regarding these concerns. They told us they were aware that monitoring within the service required improvement and that staff skills in this area needed to be developed. In order to support staff they had recently signed up to the Commissioning for Quality and Innovation (CQUIN) scheme through the local CCG. The scheme monitors care homes against a set of quality indicators designed to drive improvement and offers a financial reward for compliance. Whilst this was a positive step in looking at future developments, this did not highlight and address the current issues with the quality of service people were receiving. A number of the concerns highlighted during the first day of our inspection had been actioned when we returned to the service five days later. We will review how the implementation of these actions have been monitored during our next inspection.

The values of the service described by staff were not always demonstrated in the care provided to people. Staff told us they aimed to create a homely environment for people and provide individualised care. This aim was also stated on the provider's website, which stated, 'The friendly and well-managed environment provides an ideal setting in which we are able to respond to the needs of each resident as an individual, with courtesy and dignity at all times.' However, we found staff did not always uphold these values. Although we observed caring interactions with people there were times when the care provided was task orientated and

lacked consideration for people's feelings. The regional care manager told us they were aware that at times some staff may not always respond positively towards people. They told us they had recently implemented a dignity audit to look at these issues. Although the audit identified broad areas of concern such as not all staff treating people with respect, there was no detailed description of the concerns. No overall action plan had been implemented to ensure a positive culture was developed throughout the service.

The failure to implement effective quality assurance systems, maintain accurate records and embed a positive culture throughout the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported and valued by the management team. One staff member told us, "(Acting manager) is always on hand. So is (regional care manager and regional operations manager). I can talk to them about anything." Another staff member said, "We haven't got a manager at the moment but (acting manager) has acted up. They're great." A third staff member told us, "We have good days and bad days but the managers are always encouraging us." Staff meetings were held regularly and used as a forum to give feedback to staff on any changes planned or remind staff of systems in place. Discussions included the implementation of CQUINS, action to take during a fire or emergency and updates regarding staff recruitment.

People and their relatives were consulted about the running of the service. Relatives and resident's meetings were held regularly and people's opinions sought. Minutes included comments such as, 'The care is personal', 'Feel like I can ask anything. There is continuity in the care', 'Staff are kind and thoughtful'. In addition, survey's regarding people's experience were distributed to gain people's views. For example, a food survey was completed which showed that people would like a greater variety of snacks available. Senior staff and the catering team met to discuss actions and agreed that snacks would be made available throughout the day. We saw this was the case during our inspection.

The CQC had been notified of all significant events that happened in the service in a timely way. This meant we were able to check that the provider took appropriate action when necessary.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people were consistently provided with person centred care and had access to a range of meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people's dignity and privacy was respected at all times

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 failed to ensure the principles of the MCA were followed in order to ensure people's rights were protected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to monitor risks to people, to manage medicines safely and to ensure safe infection control procedures were in place

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	governance The provider failed to implement effective quality assurance systems, maintain accurate records and embed a positive culture throughout the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that sufficient staff were deployed in the service The provider failed to ensure staff received effective training and supervision to support them in their roles