Leonard Cheshire Disability

Seven Rivers - Care Home with Nursing Physical Disabilities

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 7 & 8 June 2017 and was unannounced.

Seven Rivers is registered as a care home with nursing providing accommodation for up to 29 people who require nursing care. They are also registered to provide personal care and both regulated activities were the subject of this inspection. Personal care is provided for up to 14 people with physical and learning disabilities, who reside within a supported living environment, within a block of flats managed by a housing association seven miles away from the care home.

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

At our last inspection in March 2016 the overall rating of this service was requires improvement. This is because we found the provider was not meeting legal requirements. For example, the overall management arrangements and auditing of people's medicines in both the care home and supported living environments were ineffective at identifying the shortfalls which we found. This meant that steps had not been taken to mitigate the risks to people of not receiving their medicines as prescribed. We also found a continued lack of investment and planning for renovation, refurbishment, redecoration of the premises and renewal of furniture and fabric. This meant that people did not live in a well maintained environment.

At this inspection we found the environment within the care home remained in need of refurbishment and decoration. Whilst there was some improvement in the management of people's medicines further action was required to improve the systems for the management of people's medicines within the supported living service. In the care home, action was required to mitigate the risks of potential harm to people from the risk of falls from windows and call bell response times.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. The registered manager followed safe recruitment practices. People who used the service had occasionally been involved in the selection and recruitment of staff. However, we found shortfalls in the support and training provided to overseas volunteers who also lived at the service to meet people's needs and ensure they had the skills and knowledge to protect people from the risk of harm.

People and relatives valued the relationship they had with the management team and told us they found them approachable and supportive. Staff were kind, caring and there were systems in place to ensure that people's human rights were respected and their rights to dignity and independence promoted.

People and or their representatives, where appropriate, were involved in making decisions about their care and support. People's care plans had been tailored to the individual and contained information about how

they communicated, plans to achieve people's goals and aspirations and their ability to make decisions. The service was flexible and responded positively to people's requests about their care and how it should be provided. People were supported to access social activities according to their personal choice, wishes as to how they lived their daily lives and preferences as to how their care was delivered.

The culture of the service was open, inclusive, empowering and enabled people to live as full a life as possible. The management team provided effective leadership to the service and enabled people to air their views through care reviews, meetings and their involvement in the recruitment of new staff.

During this inspection we identified continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service continued not to be consistently safe.

Further work was needed in the management of people's medicines within the supported living service.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. However, call bells were not responded to in a timely manner to meet people's needs for personal care.

The provider operated a safe and effective recruitment systems to ensure that the staff they employed were skilled and of good character.

We found the environment within the care home continued to be in need of refurbishment and decoration.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training that was appropriate to meet people's care and support needs. Staff had regular opportunities to update their care practice including nurse's clinical professional development. However, we could not be assured that overseas, live in, volunteers had been inducted, trained and equipped with the required skills and guidance to mitigate the risks to people's welfare and safety.

Risk to people's intake of adequate nutrition and hydration had been minimised. People's likes and dislikes had been assessed and people received a choice of snacks and meals.

Is the service caring?

Good

The service was caring.

Staff were attentive to people's needs. Staff were kind and thoughtful in their interactions with people.

Staff supported people to express their lifetime goals, aspirations

and plan towards achieving them.

Is the service responsive?

Good

People received care and support that was personalised and responsive to their needs.

Care plans were informative and documented the support people needed and how they wished it to be provided.

People were supported to pursue their leisure activities and hobbies according their personal wishes and preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well led as the provider continued not to operate effective systems and processes to proactively monitor the quality and safety of the service and provide a sufficient level of monitoring on a regular basis. This meant there was a lack of business planning which would clearly summarise the organisations aims and objectives with well-defined plans for continuous improvement of the service.

All of the staff and people we spoke with were all complimentary about the culture of the service and the management team support they were provided with.

Seven Rivers - Care Home with Nursing Physical Disabilities

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 the 7 and 8 June 2017 and was unannounced.

This inspection was carried out across both the residential care with nursing home and the supported living service to people living within 14 flats in a separate location.

The inspection was carried out by two inspectors and one specialist nurse advisor.

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 also reviewed other information that we held about the service such as statutory notifications. Providers are required to notify the Care Quality Commission about events and incidents that occur.

During our inspection across the two days we spoke with nine people living at the service, five visiting relatives, eight care staff across both services, two nurses, the registered manager and the director of operations. Some people were not able to verbally communicate their views of the service to us and therefore, we observed how care and support was provided to some of these people.

We checked the recruitment and training records for two newly appointed staff and four longer serving members of staff. We also looked at seven people's care records, including records in relation to the management of people's medicines and the quality and safety monitoring of the service across the care home and the supported living service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we identified shortfalls in the management of people's medicines. At this inspection we found some improvement.

We looked at the storage, medicine administration records and care notes for people who lived across both the care home with nursing and the supported living service. People had their prescribed medicines stored securely at both services. Where staff were responsible for the administration of people's medicines this had been recorded within their plan of care. This included an assessment of risk, a profile describing the medicines prescribed, the reasons for prescribing and guidance provided for staff, with actions to reduce any risk identified. For example, we looked at the medication administration records for an individual who had diabetes. We saw that there was a protocol for staff to follow when supporting this person in the administration of their insulin with clear instructions as to how much should be administered. Records were maintained of blood sugar readings and records recording the location site on the body for administration to ensure rotation. However, we recommended as safe practice for staff to ensure insulin pens are named and a start date recorded so as to ensure the pens are not in use for longer than one month and only used for the one named person.

Handwritten entries on MAR records were double signed when changes occurred with prescribed medicines. People told us that staff supported them with the application of their creams and lotions as prescribed. However, it was not always evident that people had their prescribed creams and lotions dated after opening and body maps in use which would provide guidance for staff as to where on the body these products were to be applied.

Some people were supported to maintain their independence in the safe, self-administration of their medicines. This was regularly reviewed to ensure people continued to be safe and provided with the option to have staff support if required.

Staff told us they received training via the providing pharmacy. The manager along with nursing staff carried out regular audits of medicines management. We carried out an audit of stock against medication administration records (MAR) in the care home and the supported living service. In the care home we found stocks of medicines tallied with the MAR records. However, for one person in the supported living service we found the stock of medicines did not tally with their MAR records. We asked the manager to investigate this and report back to us their findings. A swift investigation and response from the manager identified where the errors had occurred and the manager immediately took steps to rectify the shortfall and provided staff with guidance to avoid a reoccurrence.

The manager told us both services across the care home and supported living service were fully staffed with new staff recently recruited and who were waiting on the completion of DBS and reference checks before starting their employment. People across both services were supported by a consistent team of carers who worked together to ensure that staff sickness and holidays were covered. Staff told us that vacant shifts were in the main covered from within the staff team to ensure consistency of care to people with occasional use

of agency staff.

People who used the supported living service told us that they knew in advance what staff would be allocated to support them on a daily basis as they received a weekly planner. Changes could be accommodated at short notice to take account of appointments. People told us that if they needed urgent support they were able to telephone the duty person and their needs for support accommodated. Some people had preferences about which staff supported them and where possible this was accommodated.

Staff described to us how people's needs were reviewed and staffing flexible. For example, where allocated care hours for people living within the supported living flats were increased in response to people's changing needs and kept under review. People, staff and relatives told us that there were sufficient numbers of staff deployed throughout the day and night to meet the needs of the people who used the service. We observed staff had time to sit with people and chat. Meal times were calm and where people who required assistance to eat their meals, they had adequate staff available to ensure uninterrupted one to one support.

However, we were not assured that staffing levels were sufficient and staff effectively deployed in order to meet the needs of people using the service and to keep them safe at all times. We observed call bells were left unanswered for significant periods of time. A review of call bell monitoring logs showed us that it was not unusual for people to be left waiting for their call bell to be answered for up to 20 and 30 minutes. Two formal complaints we reviewed also evidenced the impact of this on people left waiting for assistance with their personal care. Although staff and the manager told us there was sufficient numbers of staff available at all times, there appeared to be a culture amongst the staff team which meant that assumptions were sometimes made about the urgency of people's needs and a lack of coordination amongst the staff team as to who would respond to call bells when required.

We also saw from a review of call bell monitoring forms, the management team had cited as some of the reasons for these delays; 'the lack of call pagers, staff not carrying their pagers with them, shortages of staff, only two care staff on duty at night, staff not taking responsibility for answering the call bells' and 'meal times staff serving meals as well as supporting people to eat'. Management actions described in these audits included; 'staff reminded to carry their pagers, staff reminded they are responsible for answering call bells.' Although we saw from a review of staff meeting minutes that staff were reminded of the need to respond to people's requests for assistance in a more timely manner further work was needed as this request was continually repeated with little improvement. We therefore recommend an urgent review of staffing levels in line with the dependency needs of people. We also recommend that staff have sufficient pagers available, a review of staff delegated duties including a review of care staff involvement in the serving of meals is conducted and closer scrutiny of staff as to the reasons for staff not carrying pagers and responding to calls with a more robust approach put in place to address these shortfalls.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service recruited staff in a way that protected people. A review of staff recruitment files showed us that application forms had been completed which identified any gaps in applicants previous work history. Checks were in place from the Disclosure and Barring Service (DBS) to establish if staff had any criminal record which would exclude them from working in this setting. References and DBS checks had been confirmed before staff started working at the service. This meant that the manager followed safe recruitment practices, with steps taken to assess that staff employed were of good character, competent and had the necessary skills for the work they were employed to perform.

We found further work was required to ensure people lived in a clean well maintained environment. There was personal protective equipment available for staff use which was easily located when required to prevent the risk of cross infection. Cleaning schedules were in place for staff to record when they had carried out specific cleaning tasks. However, we found shortfalls in the standard of cleanliness in the main kitchen. We found clutter on kitchen worktops, cupboards, drawers, tiling, flooring and fridge and freezer doors were found in need of cleaning. We also found a number of dried food stocks such as flour, rice, suet, semolina, cereals uncovered and open to contamination. Several items were also found to be well past their use by date including spices by as much as seven years. This meant there were ineffective systems in place to protect people and mitigate the risks associated with out of date food and health acquired infections from cross contamination. We discussed these shortfalls with the manager who took immediate action to organise a deep clean of the kitchen and removal of out of date stock and ordering of appropriate storage containers for dried food products.

At our last inspection we found people did not live in a well maintained environment, with planning and resources provided to ensure continuous improvement of the building. The provider had failed to ensure there was a schedule in place, reviewed and updated to evidence planning for refurbishment and redecoration of the premises and renewal of furniture and fabric. The provider sent us an action plan which failed to describe in any detail dates or timescales by which any works had been planned with resources agreed and timescales for compliance. This was outside of the registered manager's control as they were reliant on the provider to confirm resources were available and agree action to schedule dates for refurbishment.

At this inspection we found the environment within the care home continued to be in need of refurbishment and decoration throughout. Through the efforts of staff some areas of the service had been repainted. However, many of the doors and walls in people's rooms and communal areas were narrow and continued to have sustained damage as there was limited space for the movement of wheelchairs and hoists. The laundry room walls and ceiling had patches of perished plaster and were difficult to keep clean. Sluice room doors were not labelled and were not locked which meant people had access to machinery. External refurbishment was still required to some windows soffits and fascias. People had limited access to well-maintained courtyard gardens as overgrown trees and shrubs limited people's freedom of access. The passenger lift used to enable people access to their rooms upstairs had not been replaced and was not fit for purpose in enabling people who may otherwise do so with a push button mechanism to move around the service independently. People continued to rely on staff to be present to support them as the lift doors were large, heavy concertinaed doors which the majority of people could not access independently from a wheelchair. This limited people's independent freedom of movement.

We discussed our ongoing concerns with the manager and the director of operations. They then showed us a plan of shortly to commence proposed works, to replace the existing lift which would enable people to use this independently. The operations manager told us and provided us with email evidence of financial resources agreed at senior management level and allocated to resource a scope of planned works to enhance the building both internally and externally with timescales. This included refurbishment of bathrooms, sluice rooms, replacement of damaged doors and redecoration of various parts of the building. The manager also told us they had been allocated a budget and provided us with a planned schedule for replacement of furniture and fabrics to enhance the environment in which people lived.

People told us that they had been consulted during the assessment of risks associated with their care and treatment. We found risk assessments had been personalised to each individual and covered areas such as the risk of choking, inadequate intake of food and hydration, safe moving and handling and risks associated with the management of people's medicines. There were also risk assessments in relation to environmental

risks. However, we noted that there were some windows in upstairs rooms that opened wide and did not have window restrictors in place. We also found an area where people had access to an outside roof area via glass patio doors. There was at waist height a metal bar outside the sliding glass doors onto this area but this could easily be manoeuvred around and present a risk to people of falling from a great height. We discussed this with the manager who confirmed that there was no system in place to ensure regular checks of the windows and the roof area and no risk assessment with actions to guide staff in mitigate the risk of harm for people from unrestricted windows.

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

The provider had systems in place and staff had been trained in identifying acts of abuse and what steps to take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in reporting issues of concern such as whistleblowing and safeguarding policies and procedures to follow. Staff demonstrated a good understanding of how to recognise and report any signs of neglect and abuse. The manager had been proactive in reporting safeguarding concerns to the local safeguarding authority for investigation.

Everyone we spoke with told us they felt safe living at the service and with all the staff who supported them. One person told us, "There is not one member of staff I would not feel safe with." And another said, "They are all alright here. We are very well cared for. It's a nice place with nice staff." One relative told us, "It is a friendly place. We always feel welcome and [relative] is very well cared for and yes it is a safe environment with staff who know what they are doing. We have no worries or need to complain."

Requires Improvement

Is the service effective?

Our findings

People expressed confidence in the staff and said they presented with the skills and knowledge to meet their needs appropriately.

There was a process for induction and training of newly employed staff. Staff recently employed told us their induction prepared them to work at the service with opportunities to work alongside more experienced staff and training opportunities which included recognising and safeguarding people from the risk of abuse, infection control and food safety awareness. However, we could not be assured that overseas, live in volunteers had been inducted, trained and equipped with the required skills and guidance to mitigate the risks to people's welfare and safety.
Volunteers work programmes evidenced regular one to one working alone with people who used the service. We found that whilst adequate criminal record checks had been carried out volunteers had not been provided with any training other than moving and handling techniques. Induction check lists required to evidence that volunteers had received support and training relevant to the roles they would perform were found to be blank. This meant that volunteers had not been provided with training in understanding their roles and responsibilities including safeguarding people from the risk of abuse and what steps they should take to report abuse as well as other required health and safety training.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff competency checks had been conducted to evidence that staff had the required skills and knowledge to support people safely and competently. Nursing staff were provided with up to date revalidation and training in current best practice in nursing. There was a system in place to check nursing registration pin numbers to ensure nursing staff employed had maintained their registration to practice.

All the staff we spoke with across the care home and the supported living service told us that they felt well supported by the management team. Staff had been supported with regular one to one supervision meetings with opportunities to discuss their performance, planning for training needs and to support them in their continued professional development. Staff told us opportunities to enable open communication was provided as they had access to daily handover and regular staff meetings. A review of records confirmed this.

Staff said they had received all mandatory training which consisted of both of online and face to face training. Staff told us they were supported with training relevant to their roles and responsibilities. This included in addition to mandatory training, training in caring for the needs of people with complex health care needs such as epilepsy, dementia, autism and managing people who presented with distressed behaviours that may present a risk to others. Staff described the quality of the training as 'good' and 'thorough'. The manager told us that new staff had the opportunity to gain professional qualifications such as NVQs and were implementing the induction training for new staff such as the nationally recognised care certificate. .

Staff were able to demonstrate to us that they understood that people's capacity can change over time and described how they would seek consent before providing care and promote people's decision making.

People told us that they were in control of their care and there were no restrictions in place. One person told us, "With the staff encouragement my life has improved since living here."

All of the people we spoke with told us they were in control of choosing their meals and staff supported them as per their care plan. For example, where people required textured diets to prevent the risk of choking. They told us that staff encouraged and promoted healthy eating but also respected their choices as to what they ate and when. While staff helped them with menu planning, menu choices were not set in stone and people told us that meals were adapted to take account of how they were feeling. One person told us, "Since coming to live here I am eating more healthily and have reduced the amount of medication I take."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised by those qualified to do so under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager had completed assessments as appropriate to check people's understanding and capacity to make decisions about their lives. Where assessments indicated a person did not have the capacity to make a particular decision, or where at risk of absconding and needed their freedom of movement closely monitored by staff, there were processes in place for others to make a decision in the person's best interests. The manager understood their roles and responsibilities with regard to the need to make referrals to the local safeguarding authority in accordance with the MCA 2005 and where appropriate had made urgent applications as required. This assured us people's human rights had been considered and were being safeguarded from the risk of potential harm. However, where applications had been made to the local authority supervisory body for consideration, these had not been responded to in a timely manner. The manager recognised the need to evidence when these referrals required chasing.

Staff recognised potential restrictions to people's freedom of movement and these were appropriately managed. Staff understood the need to respect people's decisions and actively supported people with limited verbal communication to express their choices wishes and preferences. For example, we observed staff to offer choice in relation to social activities and meal choices using communication methods appropriate to the individual.

We received mixed views regarding the quality of the food. Comments included; "They should use more fresh vegetables not frozen. I have suggested cauliflower cheese or hot dogs for tea, but we haven't had them yet. I want a change from sandwiches", "The food is alright, I have no complaints, what they provide suits me fine", "I have a fridge in my room where I can keep the drinks I like and my favourite, chocolate" and "We are rarely asked what we would like to see on the menus. For tea we mostly have sandwiches or soup or burgers. On Wednesday's we have curry, I like curry."

People's nutrition and hydration needs had been assessed to support their wellbeing and quality of life. We saw that the risks of people receiving inadequate food and fluid were effectively managed. Care records contained malnutrition assessment tools which were in use and people's weights were regularly monitored. We saw that where required professional advice was sought promptly in the event of weight loss when sudden or unexplained. Care plans contained detailed information to guide staff as to the support required for people at risk of choking, including the required consistency of food. This was also available to kitchen staff involved in the preparation of meals.

We observed that staff were flexible with people in their approach to mealtimes. There were adequate numbers of staff available to support people with their meals. Staff assisted people to eat at their own pace and encouraged them with their meal with explanations of what they were eating where this was required.

People told us they could if they wished eat and drink at times that suited them. They also told us that they were provided with alternatives if they did not like what was on the menu but would also like to be more involved in the planning of seasonal menus. One relative said, "There does appear on some days a lack of healthy options with the two choices available containing high fat foods. Our [relative] has put on a lot of weight since they came here. We do recognise [relative] does have a choice in what they eat but maybe if there were some more healthy options available this might help them."

People had access to specialist, clinical support when required. We saw from a review of care records that people had been referred to the GP and other healthcare professionals when required. For example, referrals had been made when needed to dieticians and speech and language therapists when assessed as at risk of choking. People had access to physiotherapy, dental and chiropody services.

People had information recorded in relation to their health and care needs should they require within a hospital passport document. This provided important information including their personal preferences and complex care needs in a concise format, should they require admission to hospital to go with them to ensure consistency of care.

All relatives we spoke with told us they were kept informed of changes in people's healthcare conditions and informed of incidents affecting people's wellbeing. One relative told us, "They are pretty good at keeping you informed and updated. We are kept very well informed of any changes that happen." Another told us, "I could not ask for more. There is the occasional blip in communication but on the whole they are very good in contacting me so there are no surprises when I visit."

We saw that people's health and wellbeing was regularly monitored. Care plans described in detail guidance for staff in meeting people's health and wellbeing, care and support needs. People were supported to access a variety of health and social care professionals when required. People told us that they were supported with their health care needs and if required staff accompanied them to hospital and GP appointments. This was confirmed by the care records we reviewed. Staff were able to give us examples of where they had supported people with health care such as liaising with the clinical specialists such as, peg feeding specialists, dieticians and in relation to prescribed medicines, consulted with the supplying pharmacy for advice and support. Staff were aware of the specific needs of the individuals diagnosed with diabetes and the need for additional monitoring of their eye and foot care.

Good

Is the service caring?

Our findings

All of the people we spoke with in both the care home and the supported living service said they had no concerns about any of the staff. All said staff were kind and treated them with respect and dignity. Comments included, "Staff are good they have a good relationship with me", "This is a truly special place to live they are all so kind and wonderful and you can always talk to someone" and "I am very happy here. I am sure there would not be a place like this where the staff are patient, kind and understanding. They take time with you. I don't feel like a burden to them."

Staff were knowledgeable about the people they cared for and spoke with empathy and passion about their work and the people they supported. People told us they had been fully involved in making decisions in the planning of their care. They said they had been given information about the service and knew what to expect in terms of their support visits from care staff. They also told us that they were given the opportunity to discuss their care and support needs and review any changes in annual care reviews.

We observed positive interactions between staff and the people they supported. People appeared to be genuinely pleased to see staff when they approached and people were relaxed in the presence of staff. We saw that staff encouraged people to express their views and listened with interest and patience to their responses. People who expressed any form of anxiety were attended to with patience, lots of reassurance and kindness.

We asked staff how they engaged with people and ensured people were involved in the planning and provision of their care. Staff spoke with passion and enthusiasm about how they supported people to express their views, wishes and preferences. They described problem solving and trying to work out what people wanted and how they would reduce their anxiety. For example, allowing people to do as much they could for themselves and in the supported living service by changing the timing of their care calls and the member of staff who supported them to suit their needs.

We saw that guidance was provided for staff in people's care records as to their gender preferences when being supported with personal care. People told us their wishes and preferences had in practice been respected. One person told us they received support with their personal care and said staff were aware of and took steps to protect their privacy and dignity when supporting with washing, dressing and bathing.

Within the supported living service people gave us examples of where they were supported to be independent. For example, when preparing food by having support to chop the vegetables or staff supporting alongside whilst they carried out their shopping and banking. One member of staff told us how important it was to, "Never to take over, just help them."

People's care plans included personal profiles which described in good detail; 'What's important to me' and 'Things I want to achieve and change'. For example, people's care plans described how they chose to spend their day and what their night time care needs were. Some people had been provided with the opportunity to express their preferred priorities in planning for their end of life care. Advanced care plans were in place

which were well documented. These plans recorded people's preferences when they neared the end of their lives. Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACR) forms in place.

Visitors told us they were welcomed at all times into the service. People's friends and relatives were encouraged to remain actively involved in people's lives if this was their choice. One relative told us, "I can visit at any time. There is always a relaxed, calm friendly atmosphere here." Relatives were invited to be involved in regular social and fund raising events. One relative told us, "If I am here when they have a resident's meeting you are invited to attend also. They are a very caring bunch here, I cannot fault any of them." Another said, "The manager and the staff make you feel welcome. I would not want to see my relative to go into hospital you could not get any better care than they provide here."

Good

Is the service responsive?

Our findings

People and or their representatives, where appropriate, were involved in making decisions about their care and support. People's care plans had been tailored to the individual and contained information about how they communicated plans to achieve people's goals and aspirations and their ability to make decisions about their every day lives. We saw that some people had signed their care plans to evidence their involvement and agreement with its contents.

The service was flexible and responded positively to people's requests about their care and how it should be provided. People received care and support that was personalised and responsive to their needs. People and their relative's told us that a thorough assessment of their needs had been carried out before people came to stay at the service. For two people recently admitted to the service we saw that a comprehensive assessment of their care and support needs had been carried out. The information obtained following the assessment of their needs, had been used to develop a personalised care plan which described for staff their wishes and choices and the required guidance to provide safe and appropriate care.

Care plans were informative and documented the support people needed and how they wished it to be provided. Details such as how people chose to spend their time, steps staff could take to enable people to maintain their independence and how their daily routines including their night time care and support needs were to be met. For example, one care plan stated, 'please encourage me to do as much as I can for myself. I tend not to initiate care so it is important you ask me regularly what I need support with and what I can do for myself.' We noted that care plans were regularly reviewed and updated to reflect people's current care needs.

We saw evidence in people's care records that they and their relatives had been involved in the review of care provided wherever possible. Relatives told us they were encouraged to be involved in the planning and review of their relative's care when this was the wish of their relative who used the service. People told us they were regularly consulted about how they lived their daily lives through regular meetings and care reviews.

Daily records were completed by staff and showed us that people's weight, blood pressure and pulse had been monitored on a regular basis. However, we noted that there was no effective bowel monitoring system in place. We recommend given the complex needs of the people using the service there to be a need for a more robust system to ensure a more effective and timely treatment for people should this be required.

Staff demonstrated a passion and focus on enabling people to be as independent as possible. People told us staff supported them in a positive, enabling manner which supported their ability to maintain some impendence in regardless of their complex care needs. One person told us, "The staff here don't just let you lie back on be waited on. They do all they can to support where needed but challenge you to do as much as you can for yourself. This is good for me. I need it."

People were supported to pursue their leisure activities and hobbies according their personal wishes and

preferences. People told us that staff respected their wishes when they wanted to be alone and encouraged those who enjoyed the company of others to participate in group activities. We observed people pursuing their preferred hobbies such as painting, chess, reading, shopping and involvement in group activities such as cooking and quiz events. Care plans described people's personalised needs in relation to their social and emotional care needs and people important to them. Trips were regularly organised which enabled people to access and be a part of the community. For example, such as shopping, fishing, trips to the theatre, dog racing, the zoo and sports events.

There was a complaints process in place. Not all of the people we spoke with were aware of this. However, we found a clear system for logging concerns, suggestions and complaints. We noted that all concerns and complaints had been taken seriously and responded to in a timely manner with a clear audit of actions taken in response to concerns.

People said that they were supported to voice any concerns they might have and the manager had been supportive in listening to suggestions they had made to improve the service through regular residents meetings and annual surveys.
The service was responsive.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who was registered with the Care Quality Commission (CQC). The manager had worked at the service for a significant period of time. Staff told us, "The manager is approachable and supportive. We all work well as a team. It is a good place to work.", "This home is well run, always busy but we work well as a team together", "The manager and deputy are very supportive and their door is always open. It's a nice atmosphere to work in."

At our last inspection in March 2016 we found shortfalls in that the provider failed to operate a system of regular audits to assess, monitor and plan for improving the quality and safety of the service with action plans and timescales to evidence continuous improvement of the service. At this inspection we found the provider's quality and safety monitoring of the service remained sporadic and ineffective at assessing, monitoring and planning for continuous improvement of the service.

Prior to our inspection, the provider completed a Provider Information Return (PIR) which had been submitted to the CQC in March 2017. When asked what improvements they planned to introduce within the next 12 months to make their service better led? They told us the provider was introducing a new Quality Assurance Framework to provide support to services to achieve and sustain improvement. This they told us would include a full review of the Quality Improvement Team and increase the number of Quality Improvement Managers so that this can be achieved. The manager told us that other than one mock CQC inspection carried out by the provider's compliance team in January 2017 this had yet to be fully implemented.

The manager provided us with details of the internal audits that they carried out to check on the quality and safety of the service. This included medicines management, health and safety monitoring and support plan audits. Where shortfalls had been identified their response was recorded with timescales for actions to be completed. However, shortfalls identified within the management monitoring of call bells did not reassure us that action had been taken to fully address this ongoing issue and consideration of the impact on people.

The provider's audits had also failed to identify this as an ongoing issue and provide additional resources and evidence planning for improvement. The manager told us that the director of operations was required to produce quality and safety visits and monitoring reports on a three monthly basis. We were provided with reports of two visits which had taken place in the last 14 months. Both reports were very brief in detail. Other than the CQC mock inspection carried out by the provider we determined that the current system for the provider auditing of the quality and safety of the service failed to identify and effectively monitor the shortfalls we have identified at the last two inspections. For example, in relation to the ongoing issues with the environment, the monitoring of the risks of falls from windows and exposed roof areas, the lack of response to people's call bells and the training support required to keep people safe when employing overseas volunteers.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The provider is required by law to notify the Care Quality Commission (CQC) without delay of significant events affecting the welfare and safety of people who used the service. We found at this inspection the provider had failed to notify CQC as required of acquired grade three and above pressure ulcers.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Observations of how staff interacted with each other and the management of the service showed us that there was a positive, enabling culture. Staff were clear about the organisational structure and who they would go to for support if needed. Staff morale was positive. There were clear communication systems in place such as handover meetings and communication books. The provider had systems in place to support staff and monitor performance such as, supervision, appraisal and staff meetings. Staff told us they were actively encouraged to question practice and make suggestions for improvements and their ideas were listened to. Staff meeting minutes showed us that staff feedback was openly welcomed and encouraged.

Staff were passionate about their work. There was a clear staff structure in place and staff were aware of their responsibilities and roles within this. They told us that there were clear arrangements in place in the event of an emergency. Staff performance was monitored as the management team carried out competency observations of staff practice. Where shortfalls were found, additional training and support was provided. However, further work was required to evidence effective systems to support overseas volunteers in the work they performed.

There were a range of systems in place to ascertain people's views about their experience and identify areas of improvement. An annual review was conducted with questionnaires sent to relatives, staff and monthly meetings with people who used the service. However, the manager told us that in the past year no internal satisfaction surveys had been conducted and neither any annual survey carried out by the provider.

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 Personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of grade 3 pressure ulcers and above.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of monitoring audits and risk assessments to guide staff in mitigating the risks to people's safety from unrestricted windows and exposed roof areas.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider continued to fail to operate a system of regular audits to assess, monitor and plan for improving the quality of service with action plans including timescales.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing was not effectively deployed in order to ensure staff responded to call bells and meet the needs of people using the service and to keep them safe at all times.