Moorlands (Strensall) Limited

Moorlands Care Home

Inspection report

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14 March 2018

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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

This comprehensive inspection took place on 8, 13 and 14 March 2018. The first and second days of the inspection were unannounced. The provider was aware we would be returning to complete the inspection on the third day.

At the inspection in February 2017 we judged the service to be 'Requires Improvement' overall, and in the key questions of Responsive and Well-led, and 'Good' in all other areas. There was no breach of regulation at this time.

Moorlands Care Home 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.

Moorlands care home accommodates up to 67 people across two separate areas. One unit provides nursing care whilst the other unit specialises in nursing care for people living with dementia. During our inspection there were 37 people living at the home.

The home is required to have a registered manager in post. At the time of our inspection the service did not have a registered manager. The registered manager had left the home at the end of December 2017, having completed a four week handover with a new manager. However, the new manager had left the organisation. The previous registered manager had returned to the role of manager with the intention to re-apply to register with the Care Quality Commission. 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 this inspection we found that there were breaches of three of the fundamental standards of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, person centred care and the governance of the service.

People told us they felt safe. However, we identified some concerns in respect of safe care and treatment. Risks to people had not been adequately assessed or mitigated which meant people were at risk of potential harm. These related to health care needs such as the risk management of epilepsy and diabetes.

Infection control measures were poor. We saw some communal areas, people's bedrooms and equipment which was not clean.

People were not provided with care which consistently met their needs. Care records contained gaps which meant it was difficult to establish whether people had received the support they needed. Care plans did not always provide staff with the guidance they required to meet people's needs. The registered provider had

identified this as an area which required improvement and had an action plan to address this.

Quality assurance systems had identified some but not all of the issues we saw during the inspection and some of the issues known to the provider had not been rectified in a timely manner.

Staff understood how to safeguard people and overall safeguarding referrals had been appropriately made to the local safeguarding authority.

Medicines were safely managed. Essential safety checks had taken place such as gas and fire safety.

Staff had been safely recruited. There was a high use of agency staff but measures were in place to mitigate risks associated with this and the provider had a plan to try and recruit more permanent staff.

Staff described feeling supported by the manager and they had access to a range of training and supervision. Annual appraisals had not taken place and the manager agreed to rectify this.

We saw a variation in the quality of support provided to people who required assistance to eat. Overall, the lunchtime experience was positive and people had access to a variety of nutritious meals.

Staff understood the principles of the Mental Capacity Act and sought consent before they provided support. However, records associated with this required further improvement.

People had access to a range of health care professionals to support them to maintain their health.

There was a variation in the quality of activities on offer to people living at the home. People living on the general nursing unit had access to more meaningful stimulation and we saw the activities co-ordinator spent the majority of their time on this unit. However, the manager explained they hoped to recruit an additional member of staff who would concentrate on meaningful activities for people living with dementia.

People and their relatives knew how to make complaints. The home had received two complaints in the last year which had been appropriately investigated and responded to.

We were provided with positive feedback from relatives about the manager and they were pleased to see them back in post. People, relatives and staff had the opportunity to give feedback on the service via regular meetings with the manager.

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 consistently safe.

Assessment of risk and measures in place to manage risk required improvement. Some health needs, which meant people were at risk of harm, had not been adequately assessed.

Communal areas, and people's bedrooms and equipment were not always clean to maintain infection control measures.

Medicines were safely managed. Staff knew how to protect people from avoidable harm and had received up to date safeguarding training.

Staff were recruited safely and there were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had access to training and supervision to support them in their role. Staff told us they felt well supported by the manager.

There was a variation in the support people received to eat their meals.

Staff understood the principles of the Mental Capacity Act and we saw staff seek consent from people before they provided support.

People were supported by a range of health care professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed some warm, kind and compassionate interaction between staff and people living at the home.

We saw some people did not have their care needs met.

Overall relatives and people provided positive feedback about the care provided at the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not consistently provided with care which met their needs. Care plans did not always provide staff with the guidance to ensure people received the support they needed. Care records contained gaps which meant it was difficult to see whether people's care needs had been met.

People and their relatives knew how to make a complaint. The complaints policy was accessible to people and visitors.

Access to meaningful activities was variable. People living on the dementia nursing unit were not provided with the same level of stimulation as those living on the nursing unit.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The home did not have a registered manager. There had been a number of changes to the management team recently. The provider had arranged for additional management support to make the required improvements.

Quality assurance systems which were in place had identified a number of areas for improvement. We saw some key areas of concern during our inspection which had not been identified.

People, relatives and the staff team had the opportunity to meet with the manager on a regular basis to provide feedback about the running of the home.

Moorlands 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 8, 13 and 14 March 2018. The first and second days of the inspection were unannounced. The provider was aware we were returning on the final day.

Day one of the inspection was carried out by two inspectors, an inspection manager and a specialist professional advisor. The specialist professional advisor was a registered mental health nurse (RMN). On the second day the inspection team consisted of three inspectors. The final day of inspection was completed by two inspectors.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. We used information the provider sent to us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with three people who lived at the home and seven family members. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine members of staff including the home manager, supporting manager, nominated individual and the head of quality and governance.

We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for nine people who lived at the home, the recruitment and induction records for five members of staff and other records relating to the management

of the home, such as quality assurance, staff training, health and safety and medication.

Following the inspection we spoke with a health care professional who visits the service.

Requires Improvement

Is the service safe?

Our findings

One person told us, "I feel safe. I was worried about coming into a home, but I was made to feel happy. There's always something to do and we have fun." A relative said, "I don't worry when I leave. I'm quite happy with the care," another told us, "It's safe, warm and residents are well cared for."

Despite this feedback we identified some aspects of people's safety which required improvement. We identified two people living on the dementia nursing unit who had epilepsy; one person had experienced a recent seizure. However there were no measures in place to mitigate the risks associated with this. Both people spent periods of time alone in their bedrooms. Neither person had a risk assessment in respect of this health need. This meant they were at risk of harm as there were no measures in place to alert staff should the person have a seizure and there were no guidelines for staff about the action they should take if they had a seizure.

We saw one person whose dementia meant they posed a risk of harm to themselves and others. There were known incidences of harm whereby the person had hit other people and staff due to their distress. This person was independently mobile and there were no measures in place to identify when they were in communal areas. For example they were no additional checks and no consideration of assistive technology to ensure their safety and that of others. The provider had been liaising with the specialist mental health team to review the support the person needed and we could see a support plan was in place which provided staff with guidance about the person's behaviour.

Records for one person with diabetes showed their blood sugar readings were out of what would be considered a normal range. However, there was no guidance for staff about what the normal ranges were for this person and what action they should take if the person's blood sugar levels were out of normal range.

We were concerned people were not receiving consistently safe care and treatment because risk assessments and measures to mitigate risks were not always in place. Following the inspection visit we received information from the provider to confirm these risk management plans and guidance were now in place.

We saw prescribed thickening powder (which is added to foods and liquids to bring them to the right consistency/texture so they can be safely swallowed to provide required nutrition and hydration) was accessible in the bedrooms of two people. A patient safety alert has been issued by NHS England to raise awareness of the need for proper storage and management of thickening powder used as part of the treatment of people with dysphagia (swallowing problems). There have been identified safety incidents where harm has been caused by the accidental swallowing of the powder, when it had not been properly stored out of reach. The thickening powder was accessible to people as it was not stored safely and this meant people were at risk of harm.

Infection control and prevention measures required improvement. The environment on the dementia nursing unit was not clean. One person's bed had been made but it had dried faeces on the top of the duvet

and on the bottom sheet. We saw two people sat in chairs which were stained and one person had dropped food down the side of their chair. Another person laid in bed had a crash mat at the side of their bed, to reduce the risk of injury if they fell out of bed, this was not clean. Hand rails were sticky to touch and walls had dirty marks on them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

The registered provider contacted the CQC following the inspection to advise that they had implemented new policies, procedures and guidance in respect of infection control, prevention and cleanliness within the home. This documentation was shared with the CQC.

Part of the home was being renovated following a long standing issue with damp. We saw three bedrooms which were being renovated, they had concrete floors which were being dried out by industrial dryers and one room had a toilet which was being stored in there. These rooms were unlocked and accessible to people who lived in the home. On the same corridor there was a screw sticking out of the skirting board. These posed risks to people who used the service, especially those who lacked the capacity to understand environmental dangers, as the rooms were accessible and people could have injured themselves. There was no signage to warn people living at the service or visitors that work was underway. We raised these concerns with the manager and on the second day of our inspection these issues had been rectified.

On the first day of our inspection none of the bathrooms on the dementia nursing unit were able to be used for their designated purpose. A wet floor shower room was being used to store empty boxes which had been used to deliver medicines to the home; another bathroom had exposed pipework. We discussed these concerns with the manager and on the second day of our inspection we noted the main bathroom had been cleared and could be used to support people to have their personal care needs met.

Staff we spoke with demonstrated a good understanding of how to safeguard people who lived at the home. They were aware of the types of abuse and how to report concerns. Staff had received up to date safeguarding training. A member of staff told us, "I would not let something go if it's not right." The provider had a safeguarding policy which provided staff with guidance about safeguarding people who lived at the home.

We identified one incident of potential harm which had not been referred in a timely manner. This had been overlooked by the previous manager and the referral was made retrospectively. The systems for reporting safeguarding were in place however, there was evidence the previous home manager had not followed these. The registered provider was reviewing incidents to ensure appropriate steps had been taken. This work was underway during our inspection.

On the first day of our inspection we requested the home manager made six individual referrals to the safeguarding authority in respect of concerns regarding the care provided to individuals. Whilst three of these did not proceed to a safeguarding investigation by the local authority others are still being investigated. We will liaise with the local safeguarding authority regarding the outcome of these investigations.

The manager told us that they were confident they had sufficient staff to meet people's needs. There were 18 people living on the dementia nursing unit and 21 people on the general nursing unit. They provided four members of care staff and a nurse on each unit, this was in addition to ancillary staff The manager was supported by a full time deputy manager and these roles were supernumerary. Both the manager and the

deputy manager were nurses.

The home had experienced difficulty recruiting nursing and care staff. As a result of this there was a high use of agency staff. The provider had identified this issue and a recruitment consultant had been brought into the home to support with the recruitment of permanent nursing and care staff.

There were safe systems in place to ensure that agency staff were suitable to work at the home and they were provided with an induction. Staff we spoke with said despite the home relying on agency staff the deputy manager tried to ensure the same staff were used to provide consistent care for people. Relatives told us they knew staff and there was a consistent staff team. One relative said, "The staff are familiar there is always someone I know." Another relative told us, "We see familiar faces, especially over the last year, always see [name of deputy manager]."

Staff had been recruited safely. People had completed application forms, two references had been sought and a Disclosure and Barring Service (DBS) check carried out. DBS checks provide information about any convictions, cautions, warnings or reprimands and also list if people are barred from working with vulnerable adults or children. These checks help employers make safer recruitment decisions and are designed to minimise the risk of unsuitable people working in health or social care settings.

Medicines were managed safely. We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. Safe systems were in place to manage controlled drugs. Nurses administered medicines and received up to date training and competency checks.

There was a fire risk assessment in place and the fire alarm system, emergency lighting and fire extinguishers had been serviced. The home had a 'grab bag' which contained essential information for staff in an emergency. This was located in the reception area which meant it was easily accessible.

Essential safety checks had taken place. There was a gas safety certificate in place and the emergency call system and hoists had been serviced. Portable appliances had been tested.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Although we saw staff seek consent from people we found that care files did not consistently evidence people's ability to consent to the care and support provided. For example we saw care records which stated, "[name] has no capacity to make decisions." This was a global assessment of capacity. The MCA states assessments of capacity should be decision specific. We saw an MCA had been completed which related to "24/7 total nursing care" there was no rationale as to how the assessment had been completed. We concluded this was a record keeping issue.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The provider had identified this was an area of work which required improvement and had tasked an additional manager supporting the home with reviewing all mental capacity related records and ensuring DoLS were in place.

Staff told us they felt well supported by the current manager. One member of staff said, "[Name] is a good manager." We saw staff had received essential safety training which included; safeguarding, basic first aid, infection control, fire safety, medication and moving and handling training. Staff received dementia awareness training. The manager explained a dementia specialist had visited the home prior to our inspection and more specialist training would be provided for the staff team.

Records showed that staff supervision meetings had taken place in line with the provider's policy, which was a minimum of three sessions per year. Supervision meetings give staff the opportunity to discuss any concerns they might have, as well as their development needs. The manager told us staff appraisals should take place annually. However, we found due to the recent management changes these had not taken place or were overdue. The manager told us they would review appraisals for all staff members.

On the first day of our inspection we were concerned about the fluid intake for people living on the dementia nursing unit. However, following the inspection the provider supplied supplementary evidence which demonstrated that people were provided with sufficient fluids. For some people it had been identified they may be reluctant to drink, as a result of their dementia, there were protocols for staff to follow and

guidance had been sought from the GP about minimum fluid amounts and when to seek medical advice.

We observed lunch on the dementia nursing unit. Overall this was a calm and relaxed experience for people. We saw some members of care staff offered gentle encouragement to people to eat their lunch and there was music playing in the background. People were offered a choice of two hot meals for lunch and were provided with picture menus to support them to recognise the food available. People were provided with a choice of drinks.

The kitchen had been awarded a five star rating (the highest available) from the environmental health team. We spoke with the chef who told us about the range of meals on offer and how these were adapted to meet people's individual needs; for example they explained how meals were fortified for people at risk of weight loss.

However, we saw a variation in the quality of support provided to people who required assistance from staff to eat. One member of staff sat with the person and supported them to eat at a relaxed pace and they enjoyed a nice interaction. However, we saw two other members of care staff stood up when assisting people to eat. On both occasions another member of care staff intervened and reminded staff to sit with people whilst they supported them to eat.

An advanced nurse practitioner visited the home twice a week and staff sought their advice as required. In addition to this we saw records of contacts with a range of health care professionals such as GPs and community mental health nurses. This demonstrated the home sought support for people based on their changing health care needs.

The provider had identified that work was required to improve the environment for people living with dementia. Whilst there were some sensory objects available for people further work was required to make the environment dementia friendly, for example, contrasting colours on the walls to help people orientate themselves. The provider had arranged for a dementia specialist to review the home and was awaiting a full report of their recommendations.

Requires Improvement

Is the service caring?

Our findings

We observed some kind and compassionate interactions between staff and people who used the service. We saw a staff member stroking the head of someone who was feeling unwell. They offered reassurance that they would look after them and supported them to have a drink. We saw staff bent down to talk with people and referred to people by their name and knew their preferences.

We received positive feedback from people and their relatives about the care they received. One person said, "The staff are lovely." Comments from relatives included; "It's nice to have a chat [with care staff] and to have someone listen. Staff are very kind and lovely with [relative]," "The care is good. I can visit anytime I like" and, "The staff are calm and careful. We are made to feel welcome staff always ask me if I want a cup of tea."

We saw staff addressed people by their preferred names and knocked on people's bedroom doors before entering, which protected people's privacy. Staff closed people's bedroom and bathroom doors when they provided personal care which maintained people's dignity. People's confidentiality was respected and care records were stored securely.

A member of staff told us, "We give the best care here. I tell new carers, "provide care like you would to your parents", another said, "I'm here for the people who live here, that's what I care about."

However, we also saw some examples of care which was not dignified. We saw one person looked unkempt and was sat in a soiled pad for a long period of time, until inspection staff intervened. Care staff did not have the skills to provide the support one person required, as a result of this the person's basic care needs were not adequately met.

One person expressed concerns about their relative's care. They said, "He is clean and tidy today when I came in [another day] and many other days he is unshaven and his clothes are dirty. I see him wearing other people's clothes – everything he is wearing today is not his own, except his slippers. When I raise it with the unit manager there is always an excuse."

We recommend the provider review the care being provided to people to ensure people are treated with dignity and respect.

We carried out observations using the short observational framework for inspections (SOFI). SOFI is a tool used to capture the experiences of people who use services who may not be able to express this for themselves. We saw interactions from care staff were largely task focused, for example staff came into the lounge and offered drinks, however these were friendly interactions. We saw one member of staff sit with someone and paint their finger nails, they chatted away together.

However, one member of staff was on their own in the lounge with people for a period of seven minutes. During this time they did not interact with anyone. There were times when one person became distressed

and repeatedly called out, this caused another person to become upset and call out. The member of care staff did not talk to either person or offer any reassurance. We discussed this with the head of quality and governance and were told this member of staff was new and should have been shadowing another member of staff. They agreed to look into this.

Requires Improvement

Is the service responsive?

Our findings

During the first day of our inspection we saw one person who lived on the dementia nursing unit did not have their care needs met. They were left for a prolonged period without continence care. They were sat in a urine soaked chair with food debris around them. This person was a high risk of skin breakdown. Exposure to urine can increase the risk of skin breakdown. We checked this person throughout the day and at 3 pm we sought assistance for them. When we returned, an hour later, we saw their continence care needs had been met and they had been supported into clean clothing. However, they had been returned to the urine soaked chair and the food debris was still present. We saw the person looked unkempt; they had long finger nails which were not clean.

We visited another person in their bedroom, they were wearing numerous layers of clothing and there was a strong odour of urine. The deputy manager told us this person often refused care and said this, "depended on their mood." We reviewed their care plan and saw a care review had taken place with care staff and the local placing authority. This review recorded that care staff were not using strategies which had been designed by specialist health care practitioners to support the person to engage with care staff.

We reviewed the person's care plan in relation to the support they required with personal care. There was no reference to the strategies which has been designed to support the person to interact with care staff. We spoke with the deputy manager and the nurse in charge of the dementia care unit and neither member of staff were aware of these strategies. We saw a reference in the person's care plan to them being "moody." This demonstrated a lack of understanding of the person's needs.

Care being provided did not meet this person's needs. We shared our concerns with the nominated individual who advised they had asked for a further care review from the placing authority as they were concerned they were not able to meet this person's needs.

People were not consistently provided with care which met their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care.

The head of quality and governance explained they were in the process of reviewing all of the care plans and associated records. They had identified, during their audits that care planning records required improvement. The registered provider had a detailed action plan in place to ensure that new care plans, risk assessments and daily recording charts were implemented across the service.

We saw records contained significant gaps which made it difficult to establish whether people had been supported with the care they required to meet their needs. We saw gaps in the recording charts for continence care, oral hygiene, personal care. This meant that accurate and complete records were not being kept in respect of the care and treatment provided to people living at the home.

We reviewed one person's hygiene chart which was in their bedroom, however, there was no name, date of birth, room number or record of the month written on the chart. It showed the person had received assistance with oral care once on 7 March 2018; other days were blank so it was unclear whether the person had been offered or provided with this support. Records showed they had been supported with continence care on three occasions and had been assisted to have their hair washed and a shave on 7 March 2018, the last occasion where they were recorded as receiving personal care and support was on 6 February 2018.

Another person's hygiene chart showed they had not had a shave since 1 March 2018. There were five days when no continence care was recorded as being offered, given or refused. There were four occasions where the record for oral care was blank and four occasions when it was recorded as being refused. There was only one record of oral care being provided in March 2018.

We saw one person had a dressing on their right leg. The nurse on the dementia unit explained they were not aware of the extent of the wound as they had never seen it. Records were difficult to follow which meant we could not establish whether the care which the person required to heal the wound was being provided. There was no written record explaining the extent of the wound or photograph within the care plan. There was a body map which was difficult to follow as it contained a number of entries.

Following the inspection visit the provider contacted us to advise they had put in new wound care paperwork which provided clear guidance about the treatment the person required, along with a record of wounds. In addition to this photographs of wounds were added to the care plan records. We also spoke with a health care professional involved in the treatment of wounds at the home. They confirmed they had no concerns about the skin integrity of people living at the home. They said, "Nurses know people well and they follow our advice."

Therefore, we were satisfied people were being provided with appropriate care in respect of wound care management and that this was a record keeping issue.

Records were not completed accurately or in full, which meant it was difficult to establish whether people's care needs had been met.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The home employed an activities co-ordinator who spent the majority of their time on the general nursing unit. We saw people enjoyed the interaction they had with the activity co-ordinator who offered some group activities and spent one to one time with people. There were photographs on display of some of the activities which had taken place. The manager told us people enjoyed the 'Moorlands talent show' and a number of staff had taken part in this.

However, we saw less interaction on the dementia nursing unit. During the inspection we saw a 'sing along' session took place on the dementia nursing unit but there were no other activities taking place to engage people. One relative told us, "There could be more stimulation. There is a cinema room but it is not utilised." On the third day of our inspection we saw a movie night was being advertised. The manager told us they hoped to recruit an activities co-ordinator who would be employed solely to spend time on the dementia nursing unit.

Relatives told us they knew how to make a complaint. The home had a complaints policy on display which meant people and visitors could easily see how to raise concerns if they needed to. The home had received

two complaints in the last 12 months and these had been investigated and responded to. A relative told us, "The staff come to us to make sure we are happy with mum's care."

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager. The previous registered manager left the home at the end of December 2017. A new manager had been employed and there was a four week handover period when both managers worked together. The regional manager provided support to the new manager, however, the new manager was off for a period of time and then left the organisation. The regional manager provided management cover on a day to day basis during this period. However, they then left the organisation on 1 March 2018.

On the 5 March 2018 the previous registered manager returned to the home in the role of manager to offer some stability. The provider told us the intention was that the previous manager would reapply to the CQC to become the registered manager. Relatives told us they were pleased the manager had returned. One relative said, "I'm very pleased to have [Manager] back. [Manager] makes such a difference and is very caring and approachable." Another said, "The manager really improved things here."

The manager was supported by a deputy manager, who was a nurse. They worked full time and were not included in the core staffing levels which meant they had time to support the running of the home.

The provider had identified improvement was required at the home. To address this they had provided an interim support manager to work on a full time basis and the head of quality and governance was also supporting management to achieve actions which had been identified through the quality assurance processes.

An independent audit had been completed, by an external organisation, in November 2017. This had identified a number of areas where improvement was required. Infection control and cleanliness within the home was an area of concern and the audit showed it scored 62 per cent and individualised care and treatment scored 66 per cent. These areas remained of concern during our inspection.

An operations visit, completed by the head of quality and governance, took place over three days in January 2018 and identified "care plans require updating as a matter of urgency." There was an action plan in place to address this piece of work, with the intention being that all care plans would be re-written on new paperwork and would take three to six months to fully embed. However, we found some key information in care plans, in respect of the management of health care needs and risk assessments, which were not in place. This was a key priority based on the risks associated with not having this direction for care staff.

The previous manager had completed a 'daily chart audit' on 31 January 2018 and had scored this at 91 per cent. This had identified that for people requiring wound care management, a photograph of the wound was required and it had also identified gaps in fluid charts. The nominated individual had discussed this with staff at a meeting on 5 February 2018. However, during our inspection we found these issues remained unresolved. This meant that issues known to the management team and the provider had not been rectified in a timely manner.

The manager met with the staff team for ten minutes at the start of each day. These 'daily flash meetings' covered key priorities for the day and identified ongoing work required. For example, one of the meeting minutes we reviewed reminded staff about the policy of using mobile phones whilst at work and discussed the ongoing updating of care plans. This meant the manager had the opportunity to discuss any key points with staff each day. Despite this a member of care staff we spoke with described feeling like there were unrealistic expectations on staff. They said, "People are walking in left right and centre saying you should be doing this and that but there is a lack of appreciation for all the hard work staff do."

During the inspection we found it difficult to establish key information which we would expect the management team to know. For example, we were given different information from the manager about who was being provided with end of life care, who had assistive technology in place, who had wounds or pressure sores and who was subject to an authorised DoLS. Whilst we accept the manager had only recently returned to their role we would expect this information to be available within the management team.

Record keeping was poor and there were gaps in records associated with people's basic care needs such as personal hygiene charts. In addition to this some care plan records were difficult to follow and did not contain all of the key information required.

Whilst it was evident the provider was aware of a number of issues which required improvement within the service, and they had provided supplementary support to address this, the inspection found a number of concerns. People were not always provided with care which met their needs. We spoke with the nominated individual to express our concerns about the care of one person. We were told they did not think the home could meet this person's needs. They advised they would request a care review from the placing authority. This had not been identified via the provider's own systems for quality assurance. Risk assessments and measures to mitigate risk were not always in place which meant people were at risk of avoidable harm. Some areas of the home and equipment were not clean. Record keeping contained significant gaps which meant it was difficult to be assured people had received the care they needed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

During the inspection the nominated individual who was also the chief operations officer provided the CQC with an action plan to address the concerns we had identified. They also explained additional management support would be provided to ensure the improvements required were completed as soon as possible.

Following the inspection we were provided with further key pieces of information which offered the inspection team reassurance that, overall, people were being provided with the care they required to meet their needs but that records did not always reflect this.

Relatives told us they were given a choice about when they wanted relatives meetings to take place and we saw these had taken place on a regular basis. This meant relatives had the opportunity to give feedback about the running of the home and to raise any concerns they may have. We also saw evidence of staff meetings taking place on a regular basis.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. We found that notifications had been submitted by the manager when required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always provided with care which met their needs and care was not always person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health had not been adequately assessed and measures to mitigate risk were not always in place. The home was not clean and people were not protected from the risk of the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not appropriately maintained as they were not always complete or easy to follow. Quality assurance and governance systems were not robust as they did not identify and rectify shortfalls.