Country Court Care Homes 2 Limited

Lyle House

Inspection report

207 Arabella Drive
London
SW15 5LH

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18 May 2017

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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 inspection took place on 16 & 18 May 2017. The first day of the inspection was unannounced, the provider knew we would be returning for a second day.

A comprehensive inspection was carried out on 22 March 2016 during which breaches of regulation were found in relation to safe care and treatment, consent and good governance. We then carried out a focussed inspection on 21 December 2016 at which time the provider had met their action plan in response to the breaches found, however we did not improve the overall rating at this inspection.

There was a registered manager at the service, although they were not managing the service. A new manager had been recruited but had not officially started in post at the time of our inspection. 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.

Lyle House provides residential care for up to 45 older people. The home is arranged over three floors and accommodates some people with a diagnosis of dementia. At the time of the inspection, there were 41 people using the service.

People and their relatives told us that care workers spoke with them nicely, respected their choices and respected their privacy and dignity. They said they felt safe in the company of care workers.

Although we received mixed feedback about the food, people were offered a choice. There was a four week menu that was changed seasonally and there were theme days once a month. Textured modified food was available to make soft food more presentable and appetising to people who were on a soft diet.

Care workers were familiar with people's preferences such as the name they liked to be called and their dietary preferences. Staff we spoke with were aware of recent changes to people's support needs following any incidents. We observed some good examples of staff having a caring attitude, care workers supported people in a patient manner. Staff seemed to know the people and anticipated their needs. However, we also saw some examples of care practice that were not as caring as they could be.

Staff recruitment procedures were thorough and staff files included completed application forms, references, proof of identity and Disclosure Barring Service (DBS) checks. We found there were enough staff to meet people's needs, however there were occasions where a deputy manager was not available on the weekends although this was the provider's expectation.

Although the provider maintained an accurate record of training, we found that not all of the staff were keeping up to date with their training.

Risk assessments and care plans were not consistently documented or updated.

Standard risk assessments for areas such as falls, pressure sores and nutrition were in place but staff were not always completing these appropriately. Where they were completed correctly, actions were identified for staff to manage the risk.

We found that although people's healthcare needs were met by the provider and people had been referred to and assessed by healthcare professionals such as community based support services and nurses, there were occasions where care plans had not been updated to demonstrate involvement of these professionals or updated to reflect changes in their needs.

People told us they were happy with the support they received with regards to their medicines. Care workers had received training in medicines administration which included both a theoretical test of their knowledge and a practical observation. A care worker followed good practice when administrating medicines to people when we observed them during the inspection.

Care workers demonstrated an understanding of the Mental Capacity Act 2005 (MCA). Mental capacity assessments for specific areas were in place if there were doubts about a person's capacity to consent to an aspect of their care. We saw examples where people had been supported by an advocate to make decisions.

There had not been a consistent presence in the form of a registered manager for a number of years. This had resulted in some aspects of the service not being well managed. Some practices had felt the effects of this, for example the inconsistency with the risk assessments, care plans and other documents such as accidents and incident investigation reports.

The peripatetic manager had managed the service well in the period leading up to the inspection. There was evidence that they tried to listen to people's views. They had also maintained a self-audit schedule which helped to ensure that audits took place on a regular basis. Actions identified from these were followed up. A 'quality indicators report' every month documenting the number of any falls, pressure sores, people at risk of malnutrition and infections at the service was completed and used to drive improvements where necessary.

The operations manager attended the service every two weeks to provide regional support to the peripatetic manager.

We found one breach of regulation in relation to good governance. You can see what action we have 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 was not consistently safe.

Although there were sufficient numbers of staff to meet people's needs, there was not always a deputy manager on shift at weekends, despite the agreement that this should happen.

Staff had not completed risk assessments correctly in some cases. The manager told us they were in the process of reviewing and updating their risk management documents to standardise them.

Staff followed good practice when administering medicines to people. However, we noted that medicines storage could be more secure.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who received appropriate training. However, not all staff had completed refresher training as expected to keep their knowledge up to date.

Although we received mixed feedback about the food, we found that staff supported people appropriately.

People had been referred to and assessed by healthcare professionals such as community based support services and nurses.

The provider was meeting the requirements of the Mental Capacity Act (MCA 2005).

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that staff spoke with them nicely, respected their choices and respected their privacy and dignity.

However, we observed some examples of care practice that was

not caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans covered a number of areas and each care plan had an identified need, expected outcome and how people's care needs should be met.

Although care plans were evaluated every month with any updates, there was some inconsistency in the records we saw.

All complaints were reported monthly as part of the provider's quality assurance audits to determine any trends.

Is the service well-led?

Requires Improvement

The service was not well-led in some aspects.

The lack of registered manager had meant there was inconsistent practice with regards to certain aspects such as risk assessments and care planning.

A self-audit schedule was in place which helped to ensure that audits took place on a regular basis throughout the year. The provider took action where issues were found.

Lyle House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

We undertook this comprehensive inspection on 16 and 18 May 2017.

The inspection was carried out by two inspectors and an Expert by Experience on the first day and one inspector on the second day. The first day of the inspection was unannounced, the provider knew we would be returning for a second day.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection we spoke with five people using the service and four relatives. We spoke with six care workers, the chef manager, the peripatetic manager and the operations manager. We looked at seven care records, staff records, training records, complaints and audits related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We found there were enough staff to meet people's needs however there were occasions where a deputy manager was not available on the weekends as stated.

We asked people if staff were available to help if they needed assistance. They said, "Oh yes because I can't walk properly", "I think so", "Yes always enough staff" and "Don't wait long."

Care workers told us there had been some improvement in staffing, "On each shift there is a senior or deputy", "Staffing is better now" and "Every senior is given a floor to oversee."

The manager was supported by two deputy managers and five senior care workers, three for the days and two for nights. They were currently recruiting for one senior night carer. The peripatetic manager said they had implemented some changes to the staffing within the service since they had started, including ensuring there was always one deputy on shift during the day including weekends, however this was not evident in the rotas we saw.

We looked at staff rotas for the three weeks prior to and including the week of the inspection and although a deputy was on shift on some weekends, there was no deputy on shift on 29 and 30 April or the 14 May according to the rota.

There were a minimum of three care workers working on the ground floor, four on the first floor and three on the second floor. On the day of the inspection, there were two senior care workers on shift who were floating across all three floors.

We looked at four staff files. These included application forms, two references and proof of identity and address. Staff also had Disclosure and Barring Service (DBS) checks in place. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Although risk assessments were completed for people, we found there were inconsistencies in the records we saw.

We saw examples where risks had been assessed and action taken in response to areas that were identified as high risk. For example, moving and positioning risk assessments included details about which tasks involved moving and handling, why assistance was required and the equipment to be used. Where people's needs had changed, this was documented and staff were following the updated procedures. One person was initially supported using a standard hoist but this had changed to a full body hoist on the recommendation of the occupational therapist. We checked with staff and saw the full body hoist was in place and the person had the correct sling in place. Risk assessments for the use of a hoist were in place and gave guidance to staff about how to carry out this task safely.

One person at risk of falls had a plan in place to prevent falls, which included guidance for staff such as remove clutter, ensure Zimmer frame at hand, and ensure sensor mats put in place. This person's falls history information and risk assessment were up to date. They had a fall in February 2017 and their falls care plan had been updated. The falls care plan clearly showed that it had been written to reflect written guidance from a physiotherapist from the Integrated Falls and Bone Health Service who had seen the person in March 2017.

Risks around people's skin integrity were managed. For example, for each person a Waterlow risk assessment, a specific skin integrity care plan and care plan evaluation were completed. The Waterlow score gives an estimated risk for the development of a pressure sore in a given person. The associated care plan and care plan evaluation for one person documented that the person had been seen by the tissue viability nurse. The risk assessment included a request for the person to be reassessed for a pressure relieving mattress.

However, we saw other examples where staff had not completed risk assessments correctly. In one nutritional risk assessment, the record was ticked rather than given a score as required. It was not clear how the level of risk was identified using this method as the final score was supposed to be a sum of the individual scores.

One person who was identified as being at high risk of pressure sores and weight loss did not have a nutritional risk assessment. In their care plan for food and nutrition, dated 08/02/2017 the entry stated 'continues to lose weight. Please record [their] weight weekly. [Person] to have food charts completed daily.' This person's Malnutrition Universal Screening Tool (MUST) was blank. The MUST helps to identify people who are underweight and at risk of malnutrition.

There was a document called 'falls risk assessment' and another called 'risk of falls assessment'. The peripatetic manager told us the falls risk assessment was the initial assessment and the risk of falls assessment was the risk management document containing the control measures used to manage the risk identified in the falls risk assessment. However, we noted that the scoring system used was different in the two documents . In the falls risk assessment, a low risk was 5-8, medium risk 9-12 and high risk 13+. In the risk of falls assessment, a low risk was 1-3, medium risk 4-6 and high risk nine+. These different scoring systems could cause confusion and impact on a person receiving safe care in accordance with their needs.

There was a risk assessment to manage a person's diabetes which seemed to be unevenly focused on the actions to take if the person displayed signs of hyperglycaemia but needed more guidance for staff regarding what they should do if the person was showing signs of hypoglycaemia. We advised the peripatetic manager of this and on the second day they had printed some information sheets for staff.

The peripatetic and the operations manager told us they were in the process of reviewing and updating their risk management documents to standardise them. They sent us a copy of the documents after the inspection.

People told us that staff supported then with medicines and they were happy with the support. They said, "I get them every day and night, main bulk in the morning", "They give me the medication, yes", "They bring it in and I take it" and "Yes and I know what it's for and why."

Care workers had received training in medicines administration. We saw medicines competency assessments which tested their knowledge about medicines and a medicines administration assessment which was a practical observation of staff supporting people with medicines.

We observed a care worker during a medicines round. They followed good practice such as assisting people and giving them information about their medicines. They signed Medicine Administration Record (MAR) charts after people had taken their medicines and locked the medicines trolley if it was left unattended.

Staff had not taken appropriate action when people had refused their medicines. We saw one example where a person had been prescribed paracetamol four times a day. We checked the MAR chart for the period 10 March 2017 until 07 May 2017 and we saw they had not taken their last dose on any of the days in this period. We asked staff about this and they said it had been discussed with the GP but there was no record of this. We raised this with the peripatetic and operational manager at the end of the inspection; on the second day they told us they had contacted the GP who had advised them to discontinue the last dose.

We checked the medicines room and fridge temperatures with the deputy manager. We counted one controlled drug, checked the controlled drugs cupboard and book and looked at the system for returning medicines no longer required to the pharmacist. We saw that the medicines fridge was unlocked although it was in a locked medicines room. We discussed this finding with the management team during the inspection and have advised the provider to ensure that access to the room is restricted to those members of staff authorised to handle and administer medicines within the service. However if external parties have access to the medicines room then the fridge needs to be locked.

We asked people using the service if they felt safe with staff. They told us, "They are all lovely" and "Yes they keep it safe, there is always an alarm."

A care worker said, "I have never witnessed any untoward behaviour. If I did, I would say something, I couldn't let it go." Staff were aware of safeguarding procedures and who they could contact if they had concerns. Safeguarding was covered as part of the training for staff, the matrix showed that only 62% of staff had up to date safeguarding training.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who received appropriate training to equip them with the skills and knowledge to support people effectively. However, staff training was not always refreshed at regular intervals in line with the provider's policy to ensure that they maintained their skills and knowledge in particular areas.

The provider told us they had introduced the Care Certificate for new care staff with less experience in care. New staff were given 12 weeks to complete the Care Certificate. We asked the peripatetic manager if any staff had completed this as yet and she told us they hadn't. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life.

The provider maintained a training matrix with details of the training that had been delivered to staff. Training was provided in a number of areas which included basic life support, moving and assisting people, safeguarding, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), fluids and nutrition, dementia awareness, equality and diversity, person centred planning, challenging behaviours and communication skills.

Although the provider maintained an accurate record of training, we found that not all of the staff were keeping up to date with their training. For example, only 32% of staff had up to date training in how to support people with behaviours that challenge. The highest compliance level was for health and safety, 72% of staff were up to date with this training.

Supervision records were seen. Items for discussion included DoLS, policies and procedures, concerns and tasks for follow up. The provider maintained a supervision matrix which helped to ensure that a schedule was in place for staff to have a one to one meeting with their line manager.
Food and nutrition care plans were in place. These included a record of people's weights and any risks associated with nutrition. Dietary requirements were also recorded, including people's likes, dislikes, allergies, any assistance required and preferences.

We asked people and their relatives what they thought of the food and if they were offered a choice. We received mixed comments, a few people said there was too much chicken on the menu. We asked the chef about this and they said people were offered a choice but sometimes when offered alternate meals they always went back to chicken. Other comments included, "Very good", "It's alright", "I've eaten it, I don't find no problem with it", "One of the things I don't enjoy", "Could be much improved, doesn't look appetising" and "Instead of looking forward to meals I wonder what it's going to be like."

Relatives told us, "I know they do a hot meal", "[Family member] enjoys it, they always eat it", "It's good not that my [family member] eats very much", and "There's two menus, never ever complained always eats the food."

We carried out an observation at lunch. There were two choices for lunch and two choices for pudding. Staff

asked people's permission before putting aprons on them to protect their clothes. Staff offered people a fruit squash and water. Food was presented to people and when one person asked, staff explained that it was beef lasagne with mash. Another person was given sausage and chips and they said, "Sausages were nice today."

A relative came in during lunch and a person refused to sit at the table and wanted to have their lunch in the lounge which they were able to do. The relative asked their family member if they enjoyed lunch and they said, "I've eaten better."

We didn't observe a lot of staff interaction with people during lunch and the TV was changed to a music channel whilst people ate. Ketchup was offered for chips but salt wasn't, one person asked for some but staff did not hear them.

We spoke with the chef manager who spoke to us about the menu planning and food within the service. They told us they were supported by two general assistants and were recruiting for a permanent chef at the weekends. There was a four week menu that was changed seasonally. They told us they tried to vary the menu with various cuisines and once a month put on a theme day, such as Spanish cuisine. They also told us they used textured modified food to make soft food more presentable and appetising to people who were on a soft diet.

Food and fridge/freezer temperature checks were recorded daily. The kitchen environment itself was clean with separate raw food preparation areas, a sink for washing pots and a hand wash sink. There was a dry store which was well stocked with food.

People had been referred and assessed by healthcare professionals such as community based support services and nurses.

The peripatetic manager told us they were planning to introduce the 'red bag' scheme in the event of hospital admission. They had also introduced new transfer forms when people were admitted to hospital. The "Red Bag" has been developed in partnership with Epsom and St Helier Hospital Trust, Sutton and Merton Community Services, the London Ambulance Service and staff from care homes. The red bag contains standardised information about the person's general health, any existing medical conditions they have, medicine they are taking, as well as highlighting the current health concern(s). It stays with the person whilst they are in hospital and a copy of their discharge summary is placed in the red bag so that care home staff have access to this important information when the person arrives back home.

Records of visits from healthcare professionals such as GP, district nurses and therapists were kept and we also saw evidence of healthcare professional involvement in people's care. For example, ophthalmology follow-up appointments, audiologists for hearing tests, dietitians, and annual diabetes and cholesterol blood tests.

People had been referred and assessed by healthcare professionals such as community based support services and nurses, which included the Behaviour and Communication Support Service, community psychiatric nurse (CPN) and tissue viability nurse (TVN). In some cases, there was also evidence of joint reviews between external teams.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Care workers demonstrated an understanding of the MCA, telling us "Mental Capacity Act is used for people that are not able to make decisions for themselves" and "People with dementia can have capacity to decide for themselves."

Mental capacity assessments for specific areas were in place if there were doubts about a person's capacity to consent to an aspect of their care. This document guided staff through a two stage test for assessing a person's capacity. We saw one example for assessment to consent for bedrails. The outcome following the assessment was that the person did not have capacity to consent and therefore a best interests decision was made in line with the MCA. In another example, there was a copy of a MCA test in place which showed the person was able to consent to living at Lyle House. This person was supported to make their decision about staying at the service with the help of an advocate. We also saw other examples where people had been supported by an advocate.

Where people had Do Not Attempt Resuscitation (DNACPR) documents in place these had been discussed with their families where appropriate if they did not have the capacity to understand these. This decision was made in people's best interests in line with the MCA.

Where relatives had been appointed as deputies for property and affairs, these records were kept for evidence. Consent forms were signed by people's appointed deputy.

Requires Improvement

Is the service caring?

Our findings

One relative said, "I like it here, it's warm and friendly" and "They say I am becoming part of the family, I come every day."

We asked people if staff spoke with them nicely. They said, "Most are nice, there is always the odd one", "Yes but they are so busy it's a busy place", "Yeah a lot do'", "Oh yes, I try not to give too much trouble" and "The only thing is they are so rushed they don't have time to talk to you in your room."

We asked people if care workers respected their choices and allowed them freedom. One person said they did and showed us their polling card. They named the manager and said he/she would take them to vote. Other comments included, "The food, they come and ask you what you want" and "The day before we make our choice from the list (menu)." Relatives said, "They do say if [person using the service] doesn't want anything, like change into his pyjamas we don't force him" and "Yes they would."

People told us staff respected their privacy and dignity. Comments included, "They knock the door", and "Yes knock on the door before they come in." A relative told us, "[Family member] is generally covered up" and "Yes definitely."

We saw some mixed examples of care. We observed one member of staff supporting people to move with the aid of a walker and they did so in a patient manner, gently reassuring the person and not rushing them.

Staff seemed to know people and anticipated their needs. For example, one person ate using their fingers and staff seemed to recognise that this gave the person independence and they offered an extra napkin before the pudding to wipe their hands. People were offered a second drink and given time to complete the main course before being offered a pudding, staff were attentive and asked people if they had enjoyed their lunch. We saw some positive interactions, for example one person said, "God bless you, thanks" to a staff member and that staff member replied "God bless you too."

Most people were able to manage many aspects of their meal independently, for example some people handed back their empty plates to staff and did not need much assistance beyond prompting and cutting up the fish, staff knew which people were less independent and needed more support and they did this in a friendly and caring way.

We observed one occasion where one person asked for help to go out to the toilet but there were no care workers in the lounge, and they were taken to the toilet by another person who used the service. By the time any staff were found, the person was in the toilet, with door wide open and the second person helping them.

None of residents appeared to have an alternative choice of meal if they did not want what was served. One person did not want either of the menu choices on offer and asked for a boiled egg, staff did not seem to know what to do with the request and thought the person was confused and believed it was breakfast time. However, it was clear that they wanted an egg. None of the staff thought to call the chef to arrange for a

boiled egg to be brought up. This meant the person only got ice-cream for lunch and no main savoury course.

Care workers were familiar with people's preferences such as the name they liked to be called and their dietary preferences. Staff we spoke with were aware of recent changes to people's support needs following any incidents. One care worker told us, "I've been allocated as a keyworker for [people's names] but you really have to look after everyone equally."

Pre-admission documents for people included their social history, early life, family history, previous work and their recent past. The provider also made note of their personal preferences in relation to a number of areas related to daily living such as personal care, nutrition, how they liked to dress and their sleep routines.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and care plans developed to provide guidance for staff on how to meet these. Care records had front sheets with people's photograph, any alerts such as if they were diabetic, allergies and their GP details.

People's care records started with an admission sheet which contained assessments of various aspects of people's lives and needs, for example memory and understanding, personal safety, family contact and social company, and sleep.

Care monitoring records were completed daily with details of the personal care tasks performed, room checks and other comments. Daily monitoring sheets such as repositioning and skin inspection and records of food and fluid intake were kept.

Care plans covered a number of areas and each care plan had an identified need, expected outcome and detailed how the person's care needs were to be met. For example, one person had a care plan around controlling their diabetes. The expected outcome was for their blood sugar to remain stable, staff were required to offer the person a sugar free diet and to support them to see the chiropodist, attend the eye clinic and look out for symptoms such as dizziness, lethargy and sweating.

Additional care plans were in place to manage people's short term needs, for example we saw a care plan for a person who had suffered a fractured elbow. Guidelines for staff to manage this were in place. There was also an associated risk assessment and care plan evaluation in place.

Although care plans were evaluated every month with any updates, there was some inconsistency in the records we saw.

One person was seen twice by the Behaviour and Communication Support Service (BACSS) in February 2017, this contact was reflected in the health and wellbeing care plan for February 2017.

There was cross referencing in the care plans after a hospital admission, for example one person was admitted to hospital in March 2017 and the details of this were reflected across all relevant parts of their care plan.

However, some care plans had not been updated to reflect changes in people's needs. One food and nutrition care plan dated September 2016 said, '[Person] is a poor eater.' The care plan had not been updated to demonstrate involvement of a dietitian and the dietitian's recommendation for a prescribed fortified drink.

A person had a fall in January 2017, the accident form was completed however the care plan for March 2017, hadn't been updated to reflect this fall to ensure that they were kept safe.

A person with a pressure sore had been jointly reviewed by a community psychiatric nurse (CPN) from the Behaviour and Communication Support service and the district nurse on 8 May 2017. They had asked staff to make sure the person had a daily shave as hair growth could negatively impact on the healing of the pressure sore. There was a 'hygiene and personal care' care plan dated 14 September 2016, however, it had not been updated with these instructions from the community nurses. We spoke with the care workers and they told us they were doing their best to ensure this was happening as sometimes the person refused.

We asked people about the activities on offer. Comments included, "None, only one girl she goes around the floor asking people to come down", "Might do bingo", "Never heard anyone coming in doing anything", "I do play dominoes with one other resident", "We have scrabble no one understands it or wants to play", "[the activities coordinator] tries to put things" and "I have a phone, TV, radio, and paper every day, do the puzzles I walk a little way up the corridor and back."

When we asked people what aspect of the service could be improved, two of them said "More things in the afternoon" and "Do something during the day."

Relatives told us, "I don't know if [my family member] gets involved", "[The activity coordinator] puts on music and blows up balloons and they hit it", "Used to do a lot, they don't now (activities)" and "[My family member] doesn't do a lot they will walk him around, throw soft balls around." One relative said they had been to two meetings and put forward suggestions for "more activities in the afternoon to break up the monotony."

On the second day of our inspection, there was a barbeque held for people using the service. The peripatetic manager told us there was one activities co-ordinator at the service and a second was being recruited. The chef had also baked some cupcakes as part of dementia awareness week. One relative said, "When it comes to Easter/summer barbeque outside in the gardens, food, raffles, they do care."

The family contact and social company section of care plans were not always completed appropriately. In one example, the care plan did not indicate how staff would encourage and support the person with any type of meaningful activity, instead it had one entry from May 2017 which said, "Because of [person's] physical restrictions, he/she is unable to take part in most activities although he/she is always happy to sit and watch, he/she enjoys a chat and having his/her hair done." In another care plan there was nothing recorded for religious, cultural and social activities since April 2016, the person seemed very sociable and interacted with other people when we observed them.

People were not always familiar with their keyworker. They said, "There is supposed to be one, she doesn't come around and visit you", "I think so", "I don't know."

We asked people if they had ever made a complaint and if they were satisfied. We also asked who they would speak with if they had any concerns. They said they hadn't made any complaints and they would speak with, "The charge nurse first, from that things get acted on", "A carer", "First of all to a carer then asked for it to be passed to the manager", "Speak to (manager)" and "I don't know her name, the new manager downstairs."

The complaints policy was based on the Ombudsman's six principles of good complaint handling. It stated that all complaints were to be acknowledged within three days and responded to in full within 21 days and for all letters to be checked and authorised by the operations manager. All complaints were reported monthly as part of the provider's quality assurance audits to determine any trends.

We looked at the complaints register for 2017. Complaints were logged and all supporting documents were attached to the complaints records such as email correspondence and other records.

Requires Improvement

Is the service well-led?

Our findings

The lack of a long standing registered manager had resulted in some aspects of the service not being well managed.

The concerns we found with both the risk assessments and the care plans in this inspection were evident at our inspection in March 2016. Although we found there had been an improvement in these when we inspected in December 2016, similar issues were evident again at this inspection as we found that care records were not always fully completed and did not always reflect people's current needs.

In addition, we reviewed the accidents and incidents for the year. Some of the investigation reports that were required to be completed after each incident were not always fully complete. It was therefore difficult to ascertain if appropriate action had been taken in response to these. However, we did note that since the peripatetic manager had started, these investigation reports were all being completed appropriately. It was also noted that the provider's own quality monitoring processes had not identified the recording issues that were identified during the inspection.

This was a breach of regulation 17 of the Care Quality Commission (Registration) Regulations 2009.

We asked people and their relatives whether they thought the service was good and what they thought it did well. They said, "The staff are very helpful, they work too hard", "Yes. The food's nice, the rooms are nice, the carers are nice", "I think it's a lot better than the previous owner and the staff are friendly", "If you need to talk to someone they will be there", "Always get back to you", "Yes. The staff are fantastic, every single one of them knows [my family member]." One relative said, "I know the management here have done nothing but help me."

Since our last inspection, the registered manager had left and a peripatetic manager was in place overseeing the management of the home while they recruited a new manager. The peripatetic manager told us they were "Trying to get a bit of stability", "Overseeing things and giving staff some support." The peripatetic manager was being supported by the operations manager in overseeing the service whilst a permanent manager was recruited.
Care workers we spoke with told us, "[The peripatetic manager] has made a change", "I'm a bit concerned about the different managers we've had" and "The information from managers could be better, we don't always get told when things change."

We went over the statutory notifications that had been submitted to the Care Quality Commission (CQC) with the peripatetic manager. We saw that the provider took action in response to the notifications received to try and minimise incidents from occurring in the future and had followed their management plans, for example, the supervision and training of staff following certain incidents. This demonstrated the provider's commitment to improve and minimise the occurrence of similar incidents in future.

A daily flash meeting was held every day in the morning. General staff meetings were also held, the last one

on February 2017. A senior care workers meeting was held in April 2017. A staff satisfaction survey was sent out to 25 staff and 10 were returned. Staff were satisfied with the support they received but did request for personal protective equipment (PPE) to be more readily available, which the provider had taken on board.

There was evidence that the manager tried to accommodate and listen to people's views. For example, a residents meeting was due to be held in March 2017 but no one attended, therefore the peripatetic manager had held a series of one to one meetings with five people. A scheduled family meeting also had no attendees so the peripatetic manager spoke with relatives individually when they visited their family member. We noted that out of three relatives spoken with, one said they did not know who staff were or who was in charge.

In April 2017 a cleanliness survey was sent to 20 people, 15 were returned. An action plan from this survey was for more frequent cleaning in the communal areas such as the corridors and for all pictures and job roles to be displayed in reception. We discussed this with the peripatetic manager who told us they were in the process of taking staff photos to be displayed in the reception area.

Audits were used to monitor and improve the quality of care. A self-audit schedule was in place which helped to ensure that audits took place on a regular basis throughout the year. These audits included archived and new files, general audit of practices at the service, infection control, and supervision. The provider took action where issues were found. For example, a general home audit identified the need for an improved dining experience, general tidiness around the home and clinical room.

A medicines audit was competed for each floor in April 2017 looking at medicines management and stock balance. We saw some areas of improvement identified such as medicine administration record (MAR) charts not always being signed. An external pharmacy audit was due in May 2017, after the inspection.

The peripatetic manager completed a 'quality indicators report' every month documenting the number of any falls, pressure sores, people at risk of malnutrition and infections at the service. Other indicators documented included the number of hospital admissions, people that had reviews from the GP or pharmacist, the number of deaths, safeguarding referrals, people with a Deprivation Of Liberty Safeguards (DoLS) authorisations in place, compliments, complaints, accidents, significant events, staff development, staff recruitment and sickness.

The operations manager attended every two weeks and completed a provider visit record looking at the environment, medicines, feedback, care plans and a record of any relatives they had met. A corrective action report was completed to rectify any issues found which was followed up at subsequent visits.

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 17 HSCA RA Regulations 2014 Good governance Accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided were not maintained. Regulation 17 (2) (c).