Oban House Retirement Care Home

Oban House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Oban House provides residential care for up to 30 older people. Some people living at the home needed support with mobility and physical needs and others were living with dementia. At the time of inspection there were 19 people living at the home. Oban House 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.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had registered with us in March 2018.

This is the third time the home has been rated Requires Improvement. At a comprehensive inspection in January 2017 the overall rating for this service was Requires Improvement with two breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014 identified. At an inspection in September 2017 we found five breaches, and the overall rating remained Requires Improvement. These related to a continued breach of the regulation relating to good governance and four further breaches of regulation in relation to safeguarding people from abuse, providing safe care and treatment, gaining suitable consent to care and notifying us of significant incidents that occurred while people were being supported. We asked the provider to complete an action plan to show improvements they would make, what they would do, and by when, to improve the key questions in safe, effective, responsive and well-led to at least Good. We met with the provider and they confirmed their action plan stating they would have addressed the breaches by February 2018.

This unannounced inspection took place on 19 June 2018 to check the provider had made suitable improvements to ensure they had met regulatory requirements. We identified there were continued breaches as we were not assured that people's capacity was being assessed in line with best practice guidance or relevant people were involved in best interest decisions. Risks for people were not consistently being assessed, documented and mitigated to ensure their safety. Systems in place to manage accidents and incidents were not robust. Accidents and incidents forms were completed and reviewed, however, action was not always taken to ensure future risks were mitigated and lessons learned.

Quality assurance systems were not robust and did not consistently identify shortfalls in care. The registered manager and provider did not have robust oversight of the home, this is the third consecutive breach of this regulation. The provider failed to ensure they had notified CQC of an allegation of abuse and authorised DoLS applications. The provider had met a breach from the last inspection, people were now safeguarded from abuse as the registered manager investigated allegations promptly. People did not receive consistently safe care. Risks for people were not always assessed and mitigated to ensure their safety.

There was no documentation to evidence that mental capacity assessments had taken place and relevant people were involved in the process for making best interest decisions. Staff were not working in line with the provider's policy around mental capacity. This practice increased the risk that people's rights in relation to their mental capacity were being respected.

We identified areas which require improvement that the provider's systems and process had not identified. For example; lack of access to meaningful activity and incomplete records. The registered manager and provider did not have consistent oversight of working practices at the home. They did not fully understand their responsibilities in relation to their registration with the Care Quality Commission (CQC) and had failed to notify us of an allegation of abuse and authorised DoLS applications.

Some records and documents were not complete or accurate.' Some people's care plans were brief and lacking guidance for staff. This increased the risk the person would not receive care in line with their assessed needs.

Access to meaningful activity at the home was inconsistent. People gave variable feedback about access to activities at the home. One person told us, "I'd like to go out more. I've only been out twice in one year."

People's needs were not responded to consistently. People's care plans did not always reflect their social, cultural or wellbeing needs. This increased the risk that the persons need would not be met in a way that was responsive to their preferences.

People received their medicines in a safe and timely way. There were safe systems in place to manage, administer, store and dispose of medicines. When medicines were required on an 'as and when' basis, people had access to them and there was clear guidance in place about their use to ensure safe practice.

Staff received safeguarding training and knew the potential signs of abuse. They understood the correct safeguarding procedures should they suspect people were at risk of harm. The registered manager ensured staff were suitable to work in a care setting prior to them starting.

People were protected from the spread of infection and the home was clean and hygienic. Staff had a good understanding of infection prevention and control issues and they received regular training.

People were asked their consent for day-to-day decisions, for example, their choice of food and drinks. People had access to a balanced diet. We observed people's lunch time experience, there was a relaxed and friendly atmosphere We also observed staff asking people's consent before supporting them in a considerate way. People were supported by staff with the skills and knowledge to deliver effective care and support. Staff received training in relation to the needs of older people.

People's everyday health needs were managed by the staff who accessed support from a range of health and social care professionals such as GP's, a practice nurse, district nurses, social workers and a chiropodist.

People were supported by caring staff. People and their relatives told us that staff were caring and kind. One person told us, "Staff are very pleasant, caring and they do respond to calls for help." People and their relatives told us they could express their views and be involved in making decisions about their care. One person said, "They do communicate with me about my care" and "I do feel I can make decisions for myself in here."

People's independence was promoted and people felt they had the right to make choices. People were

offered the opportunity to plan for the end of their lives. Discussions had taken place with people and their families about their end of life care wishes.

People were given information in a way they could understand. The registered manager had considered the use of technology to improve people's experiences. Staff had access to electronic tablets and a system to monitor people's health needs. People and staff spoke positively of the management. One member of staff said, "Since the manager has been here it is different, there are new staff and it has improved."

People, relatives and staff were engaged in the running of the home. There were staff meetings, residents' surveys and newsletters to keep people informed. One relative told us, "You can approach the manager if there was an issue."

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks for people were not consistently assessed and mitigated to reduce the risk of harm.

Systems in place to manage accidents and incidents were not robust.

People were protected from the risk of abuse. Staff received safeguarding training and knew the potential signs of abuse.

There were safe systems in place to manage, administer, store and dispose of medicines.

People were protected from the spread of infection and the home was clean.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Mental capacity assessments were not documented and there was minimal evidence of the outcomes of these assessments.

People's needs were holistically assessed. However, this information was not always used to meet their needs.

People were supported by staff with the skills and knowledge to deliver effective care and support.

People's needs in relation to food and fluid were assessed and guidance provided for staff.

Staff worked well as a team and across organisations.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate. We observed positive interactions between staff and people.

People's privacy and dignity was respected and they were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive person-centred care that was reflective of their needs and preferences.

People did not have regular access to meaningful activities.

There was a policy in place to deal with concerns and complaints.

People were supported in a comfortable and dignified manner at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

People, their relatives and staff were complimentary of the current management and leadership of the home. However, the registered manager and provider did not fully understand their responsibilities in relation to their registration with the Care Quality Commission and there were continued breaches found at this inspection.

Systems and processes were not consistently effective in identifying issues in practice.

Records and documents were not consistently completed or accurate.

Staff felt supported by the management team. Staff and people were engaged in the running of the home.

Staff worked well with other health care professionals to ensure people's needs were met.

Oban House Residential 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.

Oban House 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.

This inspection took place on 19 June 2018 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information that we held about the home and the provider. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We reviewed other information relating to the home prior to the inspection, this included previous inspection reports and statutory notifications sent to us by the registered manager. A notification is information about important events the home is required to send to us by law.

We reviewed four people's care records and five medicine administration records. We also reviewed other records which related to the management of the home, such as staff files, training records, accidents and incidents, safeguarding records, policies and procedures and quality assurance systems. We spoke with 11 people, five members of staff, two relatives and the registered manager. During the inspection we observed care and activities in the communal spaces and people's rooms as well as outdoor spaces and observed how people were supported during the day and with their meals. We contacted a local authority quality

team so that we could further understand their experiences of the home.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in September 2017 the provider was in breach of Regulation 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured people were provided with safe care and treatment by assessing and mitigating risk to people's health and safety or ensuring the safe and proper management of medicines. The provider also had not ensured people were safeguarded against abuse. Following the previous inspection, the provider wrote to us to inform us of how they were going to address the issues and ensure improvements were made. At this inspection, improvements had been made in how the provider responds to allegations of abuse and the requirements of the breach of Regulation 13 had been met. However, there continued to be shortfalls in assessing and mitigating risks to people's health and safety. This has led to a continued breach of Regulation 12.

Risks for people were not consistently assessed and mitigated to reduce the risk of harm. Staff had completed risk assessments; however, these did not contain sufficient control measures to help minimise risk. This meant staff would not have full guidance in how to minimise risk. For example, one person was living with epilepsy and had experienced seizures. They did not have a risk assessment in place that gave specific guidance to staff on how to support them should they have a seizure. Their care plan said, 'A member of staff to stay with the person at all times' but did not include specific guidance on types of seizure and when to seek medical help. This meant that the potential risk of ill health following a seizure was not mitigated for this person. The same person required a catheter to assist them with their continence. The person had previous urinary tract infections (UTI), there was no care plan or risk assessment in place to give staff guidance on supporting the person to manage their catheter, how to notice signs of a blockage or keep it clean. This meant the person could be at potential risk of ill-health or infection as staff did not have clear guidance to mitigate this risk.

Systems in place to manage accidents and incidents were not robust. Accidents and incidents forms were completed and reviewed, however, action was not always taken to ensure future risks were mitigated and lessons learned. For example, one person had a fall and was in pain, there was no documentation that medical attention had been sought. The registered manager was unaware if the GP had been contacted and this was not documented. Actions staff took to ensure the person's safety were not logged nor was there any further documentation about how staff were to mitigate against the risk of a similar incident happening again. Another person experienced a fall and was found in their room by care staff, there was no documentation of the actions staff took and the outcome for the person. Staff told us the actions they had taken to seek medical attention for these people to keep them safe. As these actions were not documented, the registered manager did not have oversight of people's safety as there was no evidence that lessons were learnt from incidents to improve people's experience.

The registered manager and provider had not ensured people were consistently safe by assessing risks, accidents and incidents and was not doing all that was practicable to mitigate risk. The above issues meant that people's safety and welfare had not been adequately maintained at all times. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found a breach of Regulation 13, as the provider had not ensured people were protected from abuse by ensuring a timely response to allegations of abuse. At this inspection the provider had met the requirement of Regulation 13. The registered manager had ensured allegations of abuse were now being responded to in a timely manner. People were protected from the risk of abuse and were protected from discrimination. Observations showed that people were comfortable in the presence of staff. Staff received safeguarding training and knew the potential signs of abuse. They understood the correct safeguarding procedures should they suspect people were at risk of harm. The registered manager understood their responsibilities in reporting safeguarding to the local authority and we saw evidence that safeguarding concerns were reported and investigated. However, the provider did not always meet their legal requirement to inform the Care Quality Commission (CQC) of issues relating to alleged abuse. We have discussed this further in the Well-Led section of the report.

The provider ensured staff were suitable to work at the home before they started. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. There were also copies of other relevant documentation, including professional and character references, contracts and training certificates in staff files. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people.

At the last inspection we found concerns in relation to the management of medicines. This was because the management and administration of medicines was not safe. At this inspection medicines were managed safely. There were safe systems in place to manage, administer, store and dispose of medicines. Medicines Administration Records (MAR) showed that people received their medicines on time and when needed. One person told us, "I get my medication when I expect it" and another said, "I get my medication four times a day, they make sure I take it." When medicines were required on an 'as and when' basis, people had access to them and there was clear guidance in place about their use to ensure safe practice. People received their medicines by trained staff who had their competency assessed prior to administering medicines alone. We observed medicines being administered at lunchtime, the member of staff was knowledgeable and supported people to take their medicines safely.

People were protected from the spread of infection and the home was clean. Staff had a good understanding of infection prevention and control issues and they received training. The provider put preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves and staff were confident in using these correctly. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment was regularly checked and maintained to ensure that people were supported to use equipment that was safe.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in September 2017 the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that care and treatment of people was provided with the consent of the relevant person. They had not worked within the principles of the MCA by assessing capacity and ensuring the legal safeguards such as Depravation of Liberty Safeguards (DoLS) were in place when required.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection improvements had been made and DoLS were now in place for people, where required. However, it was not evident that mental capacity assessments had taken place and relevant people were involved in the process for making best interest decisions. The registered manager said that they contacted the local GP surgery to complete mental capacity assessments. There was no evidence to show that this had happened and what the outcome was. For example, the registered manager said one person had recently received a mental capacity assessment from the practice nurse, there was no documentation of the assessment or the outcome in their file. This meant people were at increased risk of having their rights infringed as there was no clear documentation to inform staff of people's needs in relation to their capacity. Best interest decisions were completed and documented by one member of staff, there was no evidence to show that other relevant people had been involved in the process, where appropriate. This meant that people were at increased risk of not being supported in a way that supports their best interest and is least restrictive.

Staff were not working in line with the provider's policy which states staff must 'prove they have come to 'reasonable' decisions about capacity and best interests, and some form of recording is essential evidence of that process' and this should be kept with the person's care plan. This meant people were at increased risk of not having their capacity assessed appropriately and in line with best practice guidance.

People were asked their consent for day-to-day decisions. Staff had undertaken recent training in this area. One member of staff described how they support people to make decisions by offering a choice of clothes to wear and what food they wanted to eat. We observed staff asking people's consent before supporting them in a considerate way and listening to people's opinions. Although this is good practice by staff, it did not mitigate the risks associated with the issues relating to mental capacity assessments and best interest decisions.

These above issues mean that people are at increased risk of not having their mental capacity assessed in

line with guidance, having their rights infringed and relevant people did not have oversight of best interest decisions. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager carried out assessments regarding people's physical, mental health and social needs prior to them moving into the home. The initial assessment processes in place considered protected characteristics as defined under the Equality Act 2010. For example, people's religion and disability. People's needs were holistically assessed, however, the information gathered about people at assessment was not always used to inform the care they received. We have discussed this further in the Responsive section of the report.

People were supported by staff with the skills and knowledge to deliver effective care and support. A person told us, "Staff seem trained, good at what they do." Staff received training in relation to the needs of people they support for example, safeguarding, medicines management and end of life care. This ensured staff had a good understanding of how to support people living at the home. Specialist training was provided to support people living with dementia. New staff received a full induction. One member of staff told us the manager "observed new staff as part of their induction" and ensured they completed shadow shifts with other staff before working alone. The registered manager said, "We check people are competent to work alone before they do to make sure everyone is safe." These checks ensured staff were competent within their roles.

People were cared for by staff that were suitably supported within their roles. Staff received supervision and said they felt supported by the registered manager and provider and felt confident in approaching them with any issues. All the staff we spoke with felt they could go to the manager at any time for support. We observed there to be an 'open door' policy in place and staff came into the office regularly to talk with the manager.

People's needs in relation to food and fluid were assessed and staff had a good understanding of people's preferences. We observed people being offered and encouraged to drink fluids and people were offered snacks and drinks throughout the day. Specific nutritional needs had been assessed and provided for. For example, people living with diabetes had their meals prepared using suitable products. On the day of the inspection, the chef was making cakes for tea, they made one with sugar free ingredients to meet the needs of people living with diabetes. People were supported to have enough to eat and drink. We observed lunchtime to be relaxed and friendly with eight people eating lunch together. People were mostly complimentary of the meals. One person told us "The meals are very good, excellent cook" and another said, "If I like something else to eat, they will try and get it for me". There was a choice of freshly cooked meals on offer. People could choose from the menu on the day and were offered an alternative to the menu, if they wished.

Staff worked effectively within the team and across organisations. A member of staff told us "We always have a manager or senior here, we work as a team and get on well." There was good evidence that staff worked well with other professionals to ensure people receive effective support. People's everyday health needs were managed by the staff who accessed support from a range of health and social care professionals such as GP's, a practice nurse, community psychiatric nurses, district nurses, social workers and a chiropodist. A relative told us "They would send for the doctor, if necessary" and their relative "gets other medical help, like chiropody".

People's mobility needs were met by the adaptation of the building. The home was two houses joined together and accommodation was split over two floors. People had access to outside space and communal

spaces. The home was pleasantly decorated and people could move safely and freely around the home. There was clear, pictorial signage to aid people living with dementia navigate the home.

Good

Is the service caring?

Our findings

We observed positive interactions between people and staff throughout the inspection and people were treated with kindness. People and their relatives told us that staff were caring and kind. One person told us, "Staff are very pleasant, caring and they do respond to calls for help". A relative said, "The residents are well looked after" and "The staff are very good, very friendly."

Care plans were not consistently person centred and there was potential risk that people would not receive person centred care. We have discussed this further in the responsive section of the report. However, staff had a good understanding of people's needs and interests and knew people well. Staff had built a friendly rapport with people. Staff gave us examples of people's individual personalities and character traits. They could talk about the people they cared for, whether they liked to join in activities and their preferences in respect of food and drink. A member of staff told us, "We find out what people like over time and adapt to meet their needs." They described one person's love of wildlife and ensured they could watch wildlife programmes. Staff took time to talk to people and have meaningful conversations, we observed staff being kind and offering emotional support for people when needed.

People and their relatives told us they could express their views and be involved in making decisions about their care. Staff took the time to listen to people and involve them in day to day decision making. We observed staff discussing different drinks people could have and options of food at lunch time. One person said, "They do communicate with me about my care" and "I do feel I can make decisions for myself in here." A relative told us, "They communicate with me about everything, like illness."

People's privacy was respected. We observed staff giving people space and privacy, they knocked and waited for consent before entering people's rooms. Staff respected people's confidentiality and understood the importance of not sharing their information inappropriately. People's personal information and care files were in lockable cabinets in the registered manager's office. The provider had ensured there were data protection policies in place. This ensured people's personal information was protected.

People received dignified care and staff adapted their approach to meet people's needs and preferences. We observed a person being assisted to transfer into an armchair in the lounge. The member of staff treated the person with dignity, ensuring they listened to the person and gave them time to move safely. Another member of staff spoke to people in a dignified manner when offering them drinks, they did this by speaking to people individually and at their level to improve communication. People looked comfortable and they were supported to maintain their personal and physical appearance, people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names.

People's independence was promoted. We saw staff encouraging independence by offering choices around food and drink and where people would like to eat their lunch. One person said, "I do feel I have independence here." Some people could access the local community independently and were able to come and go from the home freely, they were given a key to the home to enable their independence. A staff member told us they supported people to retain independence by "offering choice and promoting people to

do things themselves and to only assist when needed."

People's human rights were respected and people were treated fairly and without discrimination. For example, people living with dementia were offered emotional support when needed and staff had respectful conversations with people.

Requires Improvement

Is the service responsive?

Our findings

Access to meaningful activity at the home was inconsistent. People gave variable feedback about access to activities. Some of the comments included: "There could be more entertainment", "They have bingo and exercises but they could have more things to do" and "I'd like to go out more. I've only been out twice in one year." There were activities on offer these were, but these were only available on a Tuesday and Wednesday, sometimes external entertainers came to the home. The activities coordinator was on leave at the time of the inspection and no activities were taking place in their absence. Activities provided were generic and did not reflect the diverse interests of people living at the home. This is an area of practice that needs improvement to ensure people consistently engaged in meaningful activities.

We recommend that the provider obtains information, in respect to suitable meaningful activities for older people from a reputable source, such as the Social Care Institute for Excellence (SCIE).

People said they felt their needs were met by staff. However, some people did not always receive care that was person centred. People's care plans did not consistently reflect their social, cultural or wellbeing needs. One person was originally from another country; their cultural background was not commented on in their care plan and not all staff were aware of their background. This meant the importance of their cultural background had not been considered. Another person's care plan did not reflect their preferences around the times they wanted support, how to support them if they experienced pain and how to support them emotionally. This inconsistent approach to care planning meant there was an increased risk the person's needs would not be meant as this information was not accessible for all staff. This is an area of practice that needs improvement.

Some people received person centred care. People living with dementia received emotional support when they required, we observed staff offering reassurance when needed. We observed a person with a physical disability to be safely supported to sit in a chair of their choice. People's religious needs were met. For example, a priest came into the home to visit people and one person was supported to attend church, people's religious needs were documented in their care plans.

When people preferred to spend time alone, we saw staff being respectful of their wishes. A member of staff told us, "We have time to sit with people." They described the positive impact this time had for a person, "Initially when they were here they were sleeping and didn't want to eat, now they recognise staff, talk and spend time in the lounge." We observed this in practice, the person was chatting to others and looked happy.

People were offered the opportunity to plan for the end of their lives. Discussions had taken place with people and their families about their end of life care wishes. People had 'Do not attempt cardiopulmonary resuscitation' (DNACPR) in place if they wanted them. A DNACPR decision provides immediate guidance to those present on the action to take should someone suffer a cardiac arrest. A staff member told us that they work closely with other healthcare professionals and families to ensure people have the right care at the end of their lives.

Complaints were managed appropriately and there had been one formal complaint since the last inspection. We observed the complaints policy and procedure to be available in communal areas for people, their relatives and visitors. People said they had not needed to make a complaint recently, but felt confident they could, if needed. One person told us, "If I was unhappy about anything I would say and staff would listen" and a relative said, "I have no problems, absolutely no complaints and I'm here every day."

People were given information in a way they could understand. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. There was pictorial signage around the home to help people navigate and identify where they were and the newsletter was available in large print or with pictures to aid people's understanding.

The registered manager had considered the use of assistive technology within the home. One person could access the internet through their television and others had access to electronic tablets so they could chat to family and friends, staff supported people to use these. Staff use a system called 'DOCOBO' to monitor people's health, this system allows staff to submit information, such as people's blood pressure and pulse to the community health team who can monitor people's health and send out nurses to see them if needed. The registered manager said this had improved care for people as they can be seen quickly, nurses can give staff advice and they have seen a reduction in the number of infections.

Inadequate

Is the service well-led?

Our findings

At the last inspection in September 2017 the provider did not have effective quality assurance systems in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we issued a warning notice against the provider. This was because the provider had not ensured the quality and safety of the service was assessed, monitored and improved. They also had not ensured that risks relating to health and safety were assessed and monitored to mitigate risk.

At this inspection, although some improvements had been made, the provider had not fully complied with the warning notice issued after the previous inspection. There continued to be shortfalls in the governance along with the provider's and registered manager's oversight of the home. The provider's quality assurance systems and processes were not always robust. We identified areas which require improvement that the provider's systems and process had not identified. These included, gaps in documentation and recording, lack of oversight and risks not consistently being assessed and mitigated. This meant the provider and registered manager lacked sufficient oversight of the home.

The registered manager and provider did not have consistent oversight of working practices at the home. For example, processes for managing accidents and incidents were not consistently followed and the manager had not identified this. One person had fallen and complained of pain which resulted in a fracture. Although medical assistance was sought in a timely manner, the manager was unaware of actions taken and there was no documentation of these and how staff planned to mitigate any similar incidents in the future. The manager and provider had not ensured effective systems were in place when the manager was on leave to maintain safe care delivery, documentation was not consistently completed and requirements of their registration with the Care Quality Commission was not met due to this lack of oversight.

Since the last inspection the provider has begun to complete monthly audits of the home to monitor the quality of care being delivered. these audits did not evidence the provider had full oversight. For example, the audits for April and May both said people have 'updated care plans'. We saw care plans that were incomplete and lacking the detail staff need to support people effectively. The audit in June stated that malnutrition universal assessment tools (MUST) were 'completed' and 'all up to date.' However, a MUST we reviewed was not routinely completed, the person was identified as losing weight, however, their MUST had not been revisited since February 2018. This evidenced that the providers audits did not identify shortfalls in practice.

Some records were not complete or accurate. For example, one person had been identified as at risk of choking. A referral to the speech and language team (SALT) had been made and guidance for staff was put in place pending the assessment. The person's care plan said, 'staff to supervise when eating and drinking' and 'food to be soft and cut up small'. At lunchtime, we observed the person to be left unsupervised, their meal was not soft or cut up. The registered manager evidenced that the guidance from SALT, post assessment, said the person could continue a normal diet with thickened fluids. This was not reflected in their risk assessment or in any guidance for staff. This evidenced that the guidance for staff was not accurate and increased the risk of the person receiving care that was not in line with their assessed needs. Some care

plans did not include clear documentation relating to issues of capacity and consent, there was no documentation to show mental capacity assessments had taken place or relevant people were involved in best interest decisions. Some people's care plans were brief and lacking guidance for staff. For example, one care plan stated the person needed 'I walk unaided, I need support when I come out of my room' but did not give staff any guidance as to what support would be needed. Sections of care plans and risk assessments were not completed and left blank. Although the impact for people was low as staff knew people well, there was an increased risk that new staff would not be able to support people safely and in line with their preferences without this documentation.

There was a lack of effective systems to monitor and improve the safety and quality of care people received,. The registered manager did not have robust oversight of practices within the home and not all records were accurate and complete. This meant people were at increased risk of receiving unsafe care and care that was not in line with their needs or preferences. This is a third continued breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014

At the previous inspection the provider and registered manager did not show they understood their responsibilities in relation to their registration with the Care Quality Commission (CQC) and failed to send any notifications since November 2016. The provider and registered manager continued to not fully understand their responsibilities and failed to notify us of an allegation of abuse and authorised depravation of liberty safeguards (DoLS) applications. This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

People and staff spoke positively of the management and said that the home was improving since the new registered manager joined, they registered on 26 March 2018. One member of staff said, "Since the manager has been here it is different, there are new staff and it has improved. The manager is more up on things." Another said the manager had made "tons of difference". People were happy with the management of the home. One person said, "The management is very open, I can go to them anytime" and "I do feel there is an open-door policy with the management and the owners."

People, relatives and staff were engaged in the running of the home. There were staff meetings and senior meetings where they shared best practice with each other. The registered manager was yet to implement resident's meetings but had plans to do this to ensure people were able to give feedback about the service. People do have the opportunity to express their views through the newsletter, taking part in the annual survey and talking to staff and management. One person said, "The manager is very nice, she visits me every day" and a relative told us, "You can approach the manager if there was an issue."

Staff work together and in partnership with other organisations to ensure people's needs were met. We observed positive interactions between staff and visitors. The registered manager had identified communication as an area to improve in the home and introduced a handover book to ensure staff are aware of people's changing needs and to improve communication between shifts, staff said that this had helped keep them up to date with people's care. Staff kept people informed of health-related appointments and ensured they were supported to attend them, where necessary.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager continued to not fully understand their responsibilities and failed to notify us of an allegation of abuse and authorised depravation of liberty safeguards (DoLS) applications.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People may not be having their mental capacity assessed in line with guidance and the providers policy and relevant people may not be involved in best interest decisions.

The enforcement action we took:

We issued a Warning Notice for regulation 11; Need for consent. We require the provider and registered manager to be compliant with this regulation by 29 October 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had not ensured people were consistently safe by assessing risks, accidents and incidents and was not doing all that was practicable to mitigate risk.

The enforcement action we took:

We issued a Warning Notice for regulation 12; Safe care and treatment. We require the provider and registered manager to be compliant with this regulation by 29 October 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective systems to monitor and improve the safety and quality of care people received, the registered manager and provider did not have robust oversight of practices within the home and not all records were accurate and complete.

The enforcement action we took:

We issued a Warning Notice for regulation 17; Good governance. We require the provider and registered manager to be compliant with this regulation by 14 December 2018.