

Maples Care Home (Bexleyheath) Limited

Maples Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 25 and 28 August 2018 and was unannounced. Maples 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. Maples Care home is set over three floors and provides nursing and personal care and support for up to 75 older people. At the time of our inspection, 71 people were using the service.

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

At our last inspection on 11 October 2017, improvements were needed to the range and frequency of activities provided by the home. At this inspection we found that this was still an issue, as frequent activities were not being carried out.

At this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were breaches of legal requirement because analysis in relation to accidents and incidents was not fully carried out to look for patterns or trends to reduce these risks and learning was not disseminated to staff. There were no pictorial menus and written menus were not provided in a large font that people could read easily. The home's electronic care planning system was not always effective because during our inspection, the home's internet connection was frequently lost throughout the day. We found that care files did not have back up paper care plans and risk management plans for staff to refer to. The provider had systems in place to monitor the quality and safety of the home, however, these were not always robust nor effective because they had failed to identify and address the issues we found during this inspection. Areas of improvement identified in the annual relatives' survey 2017 remained areas of improvement identified at this inspection. They had not been rectified in a timely way. You can see what action we told the provider to take at the back of the full version of the report.

Improvements were also needed because we observed that people had to wait long periods of time for their lunch. There was limited staff interaction with people and staff seemed to be task focused. We observed that some staff were not always caring when communicating with people or assisting them.

People told us that they felt safe, and there were safeguarding procedures in place to protect people from the risk of abuse. Risks were assessed and identified and appropriate risk management plans were in place. Medicines were safely managed and people were protected from the risk of infection. There were enough staff deployed to meet people's needs and the provider followed safe recruitment practices.

Staff completed an induction when they started work and were supported through a programme of regular training and supervisions to enable them to effectively carry out their roles. People's needs were assessed

prior to moving into the home to ensure their needs could be met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff told us they asked for people's consent before offering them support. People were supported to have enough to eat and drink. People had access to healthcare professionals when required to maintain good health and the service worked with them to ensure people received the support they needed. The service met people's needs by suitable adaptation and design of the premises, with appropriately adapted bathrooms to manage people's needs effectively.

People told us staff respected their privacy and dignity and that they had been consulted about their daily care and support needs. People were supported to be independent wherever possible. People were provided with information about the service when they joined in the form of a 'service user guide' so they were aware of the services and facilities on offer.

People's care plans were reviewed on a regular basis and were reflective of their individual care needs. People were aware of the home's complaints procedures and knew how to raise a complaint. People's diverse needs in terms of religion, sexuality and culture were recorded and they were supported to meet their individual needs if required. Where appropriate people had their end of life care wishes recorded in care plans.

Regular staff and residents' meetings were held where feedback was sought from people. Staff were complimentary about the manager and the home. The provider worked in partnership with the local authority and other external agencies to ensure people's needs were planned and met. The manager was knowledgeable about the requirements of a registered manager and their responsibilities about the Health and Social Care Act 2014. Notifications were submitted to the CQC as required. The philosophy of the home was to promote people's dignity and provide person-centred care and meet people's emotional and well-being needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

There were appropriate adult safeguarding procedures in place to protect people from the risk of abuse.

Risks to people were assessed, identified and managed safely.

Medicines were managed safely.

People were protected against the risk of infection.

There was a system in place to manage accidents and incidents and these were investigated in a timely manner.

There were enough staff deployed to meet people's needs in a timely manner and the provider followed safe recruitment practices.

Good ●

Is the service effective?

The service was not consistently effective.

People were supported to have a balanced diet, but had to wait long periods of time for their lunch. There was limited staff interaction with people and staff seemed to be task focused.

People's needs were assessed prior to moving into the home to ensure their needs could be met.

Staff completed an induction when they started work and were supported through regular training, supervisions and appraisals.

Staff understood the principles of The Mental Capacity Act (2005). Staff understood and supported people to make decisions appropriately. Staff told us they asked for people's consent before offering support.

People had access to healthcare services when required to maintain good health.

The service met people's needs by suitable adaptation and

Requires Improvement ●

design of the premises.

Is the service caring?

Good ●

The service was caring.

Some staff were not always caring when communicating with people or assisting them.

People were involved in making decisions about their daily care and support requirements.

People told us staff respected their privacy, dignity and independence.

People were provided with information about the service when they joined in the form of a 'service user guide' so they were aware of the services and facilities on offer.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

There was no regular activities available for people to participate in.

Paper care plans were not available for staff to consult when the home's internet connection went down.

People had access to some information that met their communication, however, there were no pictorial menus and written menus were not provided in a large font that people could read easily.

People's religious beliefs were recorded and they were supported to meet their individual needs.

People were aware of the home's complaints procedures and knew how to raise a complaint.

Where appropriate people had their end of life care wishes recorded in care plans.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

The home's internet system was not always effective.

The provider did not have effective quality assurance systems in place to monitor the quality and safety of the service.

Areas of improvement identified in the annual relatives' survey 2017 remained areas of improvement identified at this inspection. They had not been rectified in a timely way.

There was a registered manager in place.

Regular staff and residents' meetings were held and feedback was sought from people.

Staff were complimentary about the manager and the home.

The provider worked in partnership with the local authority to ensure people's needs were planned and met.

Maples 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 checked whether the provider was 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 25 and 28 September 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist nursing advisor 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 looked at the information we held about the service. This included statutory notifications that the provider had sent CQC. A notification is information about important events which the service is required to send us by law. We usually ask the provider to send us in the Provider Information Return. However, on this occasion the provider was not asked to complete a Provider Information Return. 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. We took this into account when we inspected the service and made the judgements in this report. We also asked the local authority commissioning the service for their views and used this information to help inform our inspection planning.

We spoke with six people using the service, five relatives, eight members of care staff, the chef, the registered manager and deputy manager. We reviewed records, including the care records of 11 people using the service, recruitment files and training records for six staff members. We also looked at records related to the management of the service such quality audits, accident and incident records, and policies and procedures.

Is the service safe?

Our findings

People told us that they felt safe. One person said, "Yes, I feel safe". Another person said, "Oh, yes, I feel safe, particularly at night, because I know staff are around."

People were protected against the risk of abuse. There were appropriate safeguarding procedures in place and staff had a clear understanding of these procedures. Staff told us they would contact the registered manager if they had any concerns. Records confirmed that staff had completed safeguarding training and they were also aware of the organisation's whistleblowing policy and told us they would not hesitate to use it if required. One staff member said, "I would go straight to the registered manager, I know they would immediately deal with it." The registered manager followed safeguarding protocols and submitted safeguarding notifications when required to the local authority and CQC.

Risks to people were assessed, identified and managed safely. Risk assessments were carried out in relation to medicines, falls, nutrition, mobility, skin integrity and communication. Risk management plans included detailed guidance for staff on how to manage these risks safely. For example, where one person was at risk of falls and used a walking aid to mobilise. The person had a risk management in place for falls that recorded the support they needed from staff to ensure safe moving and handling. This included ensuring that the person had their walking aid next to them within easy reach. The person had a sensor mat next to their bed so staff were alerted when the person got out of bed and hourly checks were carried out during the day and at night. Risks were reviewed regularly and risk management plans were updated to ensure they remained relevant to people's current needs and conditions. People had individual emergency evacuation plans which detailed the level of support they required to evacuate the building safely.

Medicines were managed safely. Medicines were appropriately stored and could only be accessed by staff who had been trained and assessed as being competent in medicines administration. Medicine Administration Records (MARs) were legible and completed accurately. Medicines that had been prescribed to be taken 'as required' had information and individual protocols in people's medicine records to guide staff on their use and were recorded on MAR charts. When topical creams were administered, records were completed to demonstrate that people had received these medicines. Fridge temperatures and medicine room temperatures were recorded and monitored daily indicating that medicines were stored at the correct temperatures to ensure they remained effective. This meant that people received their medicines as prescribed by health care professionals.

People were protected against the risk of infection. The home was clean throughout and there were no malodours noted. There was an infection control policy in place and staff had received training in infection control. We observed staff wearing personal protective clothing (PPE) which included disposable gloves and aprons and washing their hands before supporting people with personal care. Staff spoke confidently about the action they would take to minimise the risk of infection. One staff member said, "I wear gloves and aprons when assisting people."

There was a system in place to manage accidents and incidents and these were investigated in a timely manner. We saw records included details of accidents or incidents and what actions were taken. For

example, one person suffered a fall, staff assessed the person for injuries, the person's family was notified and their care plan and risk assessment was updated. There were enough staff deployed to meet people's needs in a timely manner. One person told us, "Yes there are enough staff, but they are very busy." The registered manager told us that staffing levels were determined using a dependency tool based on the level of support people required. Staff rotas were planned in advance so staff knew what shifts they were working. The registered manager said that the home did use agency staff on a regular basis, but for consistency only selected agencies were used and the same agency staff covered shifts when needed.

The provider followed safe recruitment practices to ensure that only suitable staff could work with people. The provider carried out the necessary recruitment checks before staff started work. Staff files we reviewed included completed application forms, details of employment history and qualifications. References had been sought and proof of identity had been reviewed and criminal record checks had been undertaken for each staff member. Checks were also carried out to ensure staff members were entitled to work in the UK.

Is the service effective?

Our findings

During this inspection we saw that improvements were needed after observing a lunchtime meal. We saw people were supported to have a varied and balanced diet. There was a choice of meals on offer and staff explained that people were asked on a daily basis for the meal choices. However, we saw a new staff member informing an experienced staff member that one person did want to eat fish that day and only wanted a pudding. The new staff member was told to ignore the person and they were not offered an alternative meal.

We also saw that people were waiting between 30 to 50 minutes for their lunchtime meal. The person who had to wait 50 minutes had asked for an alternative meal, a jacket potato. Staff confirmed that the kitchen had lost the person's order. We observed one person walking out of the dining room and standing in the corridor, they said they had left the dining room because they were fed up waiting for their lunch to arrive.

We brought these issues to the registered manager's attention, who immediately went and spoke to the person who confirmed that they did not want fish. They also declined any alternative meal, they reiterated to the registered manager that they just wanted a pudding which they were immediately provided with. The registered manager also took action by speaking to the respective member of staff. The registered manager also confirmed, they would speak to the chef about the lost alternative meal order.

We observed staff not always knowing what their roles were during the lunchtime meal. We observed them standing together in the dining areas waiting for instruction without informing people why there was a delay. When they did start serving meals and assisting with meals we saw that staff were task focused and did not interact with people. We also heard one person asking for a cup of tea at 4pm on the first day of inspection and being told by a staff member they would have to wait until 5pm when dinner was served.

We brought this to the registered manager's attention who told us that team leaders allocated staff lunchtime duties. They said they would speak to team leaders to ensure that staff were clear about the lunchtime duties and that they needed to interact with people to let them know why the meal was delayed. They also said that people could have a drink or something to eat whenever they wanted to during the day and all staff would immediately be reminded of this.

We also saw that up to date menus were not displayed on the morning on the first day of our inspection, however during the course of the day this had been rectified. However, the menus displayed were in small writing and people would not be able to read the small print easily. People living with dementia could not always identify or remember what meals they had ordered in the morning, there were no pictorial menus to help them to choose their preferred meals and they were not physically shown the meal choices on offer at lunchtime. We observed one person asking a staff member what there was on offer for lunch, the staff member could not help as they did not know.

The registered manager told us that this was an agency staff member, but they would speak to team leaders about ensuring all staff were aware of the meals on offer. We will check this at our next inspection.

The service met people's needs by suitable adaptation and design of the premises, which included appropriately adapted bathrooms to manage people's needs effectively. However, improvements were needed as the home did not have appropriate signage to help people to orientate themselves easily. The registered manager showed us that this was an area that had been highlighted in their management plan. We noted that people's names were displayed outside their bedroom doors and bedroom doors were painted different colours. This enabled people to easily orientate themselves in easily identifying their own bedrooms. People's bedrooms were decorated with their own personal effects such as furniture, pictures and photos.

People's dietary needs were assessed and care plans included guidance for staff on how to support them. For example, if people required a low sugar, low salt or high fat diet. The chef also had a list of people's dietary requirements to ensure they were meeting people's needs. People's allergies were also recorded. Staff we spoke to were also knowledgeable about people dietary needs. One staff member said, "One person has a gluten free diet, the kitchen is aware of this as are all staff. We ensure that the person's meals are all gluten free before they eat their meals" One person said, "The food is lovely".

People were assisted to eat and drink when required. They were able to eat at their own pace and were unrushed. One relative said, "My [relative] is eating and drinking a lot more than when they first came here. The staff member feeding her is fantastic. Staff regularly monitor her weight, and emailed us with the results. My [relative] has really picked up"

People and their relatives told us that staff were knowledgeable and understood their roles well. One person said, "Staff do know their roles well. They gave me a frame and have really helped me to walk again which I thought would never happen." Another person said, "Yes, staff do understand my needs, they are very good." A relative said, "Staff do understand [my relative's] care needs and staff are well trained."

Staff were supported to carry out their roles effectively. When new staff joined the home, they completed an induction which was based on The Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. Records showed that staff completed a programme of training which included safeguarding, manual handling, mental capacity act, infection control, dementia, health and safety and first aid. We saw that refresher training courses were booked in advance for staff to ensure their training remained up to date. Staff told us that they shadowed more experienced staff when they started work to build up their confidence and get to know the people using the service. One staff member said, "Yes, my training is all up to date. I completed an induction and I also shadowed an experienced member of staff. That was very helpful, it helped me to get to know people and their individual needs." We saw that agency staff also completed an induction before they started to work at the home and covered areas such as policies and procedures, safeguarding and fire safety. One agency staff member said, "The induction was very good and easy to understand, I don't feel like an agency staff member, I feel part of the permanent staff team."

Records showed that staff received regular supervisions. Areas discussed within supervisions included performance, training, infection control and policies. One staff member said, "Supervisions are very good, I get to ask for help, discuss training and get feedback from my manager. I will be starting my NVQ in social care next month."

Assessments of people's needs were carried out prior to them moving into the home. The registered manager told us that people's needs were assessed prior to them moving into the home to ensure their needs could be met. These assessments, along with referral information from the local authority were used in producing individual care plans and risk assessments. This was to ensure that staff had the appropriate

guidance to meet people's individual needs effectively. The home used recognised tools such as Malnutrition Universal Screening Tool (MUST) to assess nutritional risk.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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). The provider followed the requirements of DoLS and had submitted applications as required. We saw that where DoLS applications had been authorised that the provider was complying with the conditions applied under the authorisation. Capacity assessments were completed and best interests' decisions made where people lacked capacity to make specific decisions for themselves. For example, when people required the use of bedrails. We observed staff seeking people's consent before supporting them with their needs and explaining to people how they were going to support them. For example, one person required support to drink, we observed a staff member asking the person if they would like support, before actually assisting them. One staff member said, "I do talk to people and explain how I am going to assist them and if they actually want my help."

People had access to healthcare professionals when required to ensure their day to day health and wellbeing needs were being met. The provider worked with other organisations to deliver effective care to people, these included a GP, dieticians and tissue viability nurses. Staff followed recommendations from healthcare professionals and reported any changes in people's health. We saw that one person had an information pack which travelled with them to hospital, this included a summary of known risk areas, care need summary, details of communication needs, recent observations and a copy of their MAR. This meant hospital staff had up to date information about the person's care needs to provide consistent care.

Is the service caring?

Our findings

People and their relatives told us that staff were kind and patient. One person told us, "Staff treat me kindly." A relative said, "Yes, staff are kind and considerate."

The atmosphere throughout the home was calm and friendly and we saw staff took their time and gave people encouragement whilst supporting them. People were well dressed and looked comfortable. People responded positively when staff approached them. We saw staff interacting with people in a caring and compassionate way and assisting people in an unrushed manner. Staff addressed people by their preferred names and showed compassion and understanding. For example, when one person was anxious, a staff member used distraction techniques by reassuring them, talking to them calmly and taking them for a walk.

People's privacy and dignity was respected. We saw staff knocking on people's doors and waiting for permission before entering and closing doors behind them. Staff told us they closed curtains and ensured there was no-one else in the room when they assisted people with personal care. One person said, "Staff always knock before entering the room". A relative said, "Staff absolutely respect my [relative's] dignity. One staff member said, "I always knock on people's doors and wait for them to invite me in. I always close curtains and doors." People's information was kept confidential by being stored in locked cabinets in the office and electronically stored on the provider's computer system. Only authorised staff had access to people's care files and electronic records.

Staff told us and we saw that they promoted people's independence by encouraging them to walk and carry out aspects of their personal care such as eating and drinking and choosing their clothes for the day. One staff member said, "I think it is important to allow people to do what they can for themselves for as long as they can. I always encourage people to walk short distances to maintain their mobility and eat and drink independently if they can."

People and their relatives were involved in making decisions about their daily care such as the time they liked to get up or go to bed and the clothes they liked to wear. Staff were knowledgeable about people's individual likes, dislikes and preferences such as their hobbies and the foods they liked. For example, one staff member said, "One person will only have cornflakes with cold milk for breakfast. We all know the milk has to be really cold." Another staff member said, "There are two people who really enjoy reading the newspaper every morning. There is a staff member who brings newspapers in for them every day." People were involved in decisions about their daily care such as what time they wanted to wake up or go to bed and what they wanted to wear.

Staff told us that people's relatives and friends were encouraged to visit them at the home in order to maintain relationships that were important to them. Staff said that relatives and friends were welcome at any time and there were no restrictions on visits to the home.

People were provided with information about the service when they joined in the form of a 'service user guide,' which included the complaints procedure. This guide outlined the standard of care to expect and the

services and facilities provided at the home.

Is the service responsive?

Our findings

At our last inspection in October 2017, we found improvements were needed in relation to the range and frequency of the activities provided to ensure people's individual needs were met.

At this inspection we found improvements were still needed in relation to the range and frequency of the activities on offer. There were two part-time activity coordinators, who attended the home five days a week. We saw that there was a weekly activities planner in place, however the planner was not up to date. On the first day of our inspection we saw that no activities had been planned for all three floors and neither of the activities co-ordinator were present, this was due to it being one co-ordinator's day off and the other was on holiday. We saw that there were no meaningful activities on offer to help stimulate people living with dementia such as sensory soft toys, memory games and reminiscence activities. We also noted that there was no music or television on in lounges to keep people entertained and people were asleep in their armchairs for most of the day.

People and their relatives told us there were no activities on offer on a regular basis. One person said, "I am totally bored here. There is no activity, no company, I just feel lonely. I just want to get out." Another person said, "Surely they could arrange bingo." A relative said, "Staff only put music on when I ask or insist." The registered manager told us that they did not have a music licence to play the radio, but would further look into this and ensure that CDs were played in communal areas.

The registered manager told us that since the last inspection they had regularly been offering and carrying out a range of activities. However, in July and August 2018 they lost two heads of activities and had been having trouble to recruit activities staff. They told us that the week following the inspection on 2 October 2018, the home was going to be receiving training from an activities company. The purpose of this was for all staff to be trained to deliver activities to people using the service. The registered manager told us that carrying out activities would be part of staff's daily duties to ensure that there was a programme of daily and meaningful activities offered and delivered.

We met with both activity coordinators on the second day of our inspection and they told us that presently there were not enough staff to carry out activities for all three floors on a daily basis. One co-ordinator said, "At the moment, we haven't got enough staff to deliver activities but hopefully this will change next week. The other co-ordinator said, "We have lost activities staff over the last two months, that's why we are in the position we are in now. But the ' training for all staff is going to take place next week, so this will make sure that activities are take place on a daily basis as all staff will be required and rostered to deliver activities." We will check the progress of this at our next inspection.

On the second day of our inspection we saw that the home had pre-arranged for a collection of classic cars to visit the home for people and their relatives to go outside and enjoy. People were then offered tea and coffee and a selection of cakes as part of a Macmillan coffee morning. We also noted that an 'Elvis' night had been planned in advance for that evening.

Staff were required to look at electronic care plans for people. Paper care plans were not available for staff to consult when the home's internet connection went down. This was necessary for agency staff members who did not always know people well and required quick access to people's care plans if required. However, on the second day of our inspection the registered manager showed us that all people using the service had a paper care file in place.

From April 2016 all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, so that they can communicate effectively. The provider had assessed people's communication needs and the information was provided in a format which met their needs. This included, providing information to people in a format they could understand if they were unable to communicate, such as large print. However, improvements were needed as there were no pictorial menus and written menus were not provided in a large font that people could read easily.

We brought this to the registered manager's attention who showed us that they had identified the issue of lack of signage and this was part of the home development plan. They would also be looking into making available pictorial menus and written menus in larger print. We will check this at our next inspection.

People's diverse needs were supported and respected. Care plans documented people's spiritual needs, sexuality and culture. A spiritual representative visited the home on a monthly-basis so that people who chose to could practise their faith.

People's care and support needs were being met and people were involved in planning their care. People's needs were assessed and care plans had been planned and developed based on an assessment of their needs, which had been carried out by the provider together with the local authority where they had commissioned the service. Care plans contained information about people's desired outcomes, such as increasing their mobility. Care plans also included details of the support people required and covered areas such as maintaining a safe environment, mobility, medicines, communication, continence, nutrition and hydration, personal care, skin integrity, preferred daily routine and night time support/sleeping. This also included the number of staff people needed to support them on a daily basis and the equipment they required, such as walking aids. Care plans included information about people's life histories, hobbies, choices and preferences as well as information about the things that were important to them. Staff we spoke with knew people well and could describe people's care and support needs in detail.

The service had an effective system in place to manage complaints. The service had a complaints policy in place and a system to log and investigate complaints. People and their relatives knew how to raise a complaint if they needed to. Complaints were investigated in line with service's complaints policy and in a timely manner and the complaints file included forms for recording and responding to complaints. One relative told us that they had to make a formal complaint but were satisfied with how the registered manager handled and resolved the matter.

People were supported with end of life care when required. The home did not currently support people who were considered to be at the end of their lives. The registered manager told us that if they did then they were aware of best practice guidelines and would consult with relevant individuals and family members where appropriate to identify, record and meet people's end of life preferences and wishes. Where people do not wish to be resuscitated we found Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms completed and signed by the people using the service, their relatives, where appropriate, staff (clinical care coordinator) and their GP to ensure their end of life care wishes were respected.

Is the service well-led?

Our findings

The home had electronic care records. Improvements were needed as during our inspection, the internet service frequently lost signal which meant that staff were not always able to access or update care records when required. Staff we spoke to told us that this was a frequent occurrence and made it difficult at times to complete their tasks in a timely manner. For example, we saw one staff member was updating a care plan when the internet signal was lost, this meant that the staff member had to wait for connection to be restored before being able to complete updating the care plan. One staff member said, "It does put pressure on staff when the internet goes as we can't finish what we are doing and have to come back to it." Another staff member said, "I have to leave post- it note to remind myself what I have to do when the internet goes down. It's not good and does need to be sorted out." This meant that staff were not able to complete records in a timely manner.

Staff had access to tasks via handheld devices but not care plans themselves. If the internet lost connection then completed tasks would appear on the main electronic the system later when connection was restored. However, staff would not be able to monitor whether tasks such as repositioning had been completed at the correct times without access to the system. We asked the deputy manager how staff would be able to identify when a person had last been repositioned when the internet was not working and they told us that they would not be able to do so. There was a business contingency plan for emergencies, however there was no contingency plan in place for when they internet failed.

We brought this to the registered manager's attention, who said that they did not have access to a fast internet connection. However, going forward they would put paper care files in place that staff could update if the internet connection was lost. This was completed by the second day of our inspection.

The provider had systems in place to monitor the quality and safety of the home, however, these were not always robust nor effective because they had failed to identify and address the issues we found during this inspection. This included analysis in relation to accidents and incidents was not fully carried out to look for patterns or trends to reduce these risks and learning was not disseminated to staff. Not having any contingency plans in place to ensure staff had access to up to date care plans and risk assessments when the internet connection was lost within the home. To carry out regular audits in relation to how long people were waiting for their meals and ensuring that information was available to people in a format they could understand, namely pictorial menus and menus written in a large font.

We saw that annual surveys for relatives were carried out to obtain people's feedback about the home. However, in the relatives' annual survey for 2017, one of the main issues was the lack of activities on offer as well as the quality of activities not being suitable. Although the survey had been analysed and an action plan had been developed we found ongoing concerns regarding activity provision at this inspection.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post. The manager was knowledgeable about the requirements of a registered manager and their responsibilities about the Health and Social Care Act 2014. Notifications were submitted to the CQC as required. The ethos of the home was to provide people with person-centred care as well as meeting people's emotional and well-being needs. One staff member told us, "I think staff aim to provide the best care they can and yes I think they do meet the ethos of home". The manager told us that they worked closely with the local authority to meet people's needs. The local authority confirmed this.

People, their relatives' and staff we spoke to were complimentary about the manager. One person said, "The manager is always around." A relative said, "if anything goes wrong, the registered manager always keeps me informed." A staff member said, "The registered manager is great, they are approachable and has an open-door policy." Another staff member said, "The registered manager is very good, they have really turned the home around."

The registered manager said that they did not carry out annual resident surveys as they did not receive any feedback in the last few years. Resident and relatives' meeting were held regularly to obtain feedback from people about the home. We saw meetings were minuted and the last meeting in July 2018 discussed areas such as introduction of the electronic care planning system, staffing, healthcare visits, such as flu jabs and menus. Regular staff meetings were held. Minutes of the last staff meeting for July 2018 showed items discussed included staffing, activities, and people using the services. One staff member said, "I attend staff meetings and they are good. We get to discuss issues we have as a team and get feedback about what's taking place in the home"

The registered manager told us they worked in partnership with other agencies, including local authority commissioners and healthcare professionals who were involved in supporting people. We contacted staff from a commissioning local authority who confirmed that they were happy about the care and support people received.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The providers internet system was not always effective.</p> <p>The provider did not have effective systems in place to assess and monitor the quality and safety of the service.</p> <p>Areas of improvement identified in the annual relatives' survey 2017 remained areas of improvement identified at this inspection. They had not been rectified in a timely way.</p>