Applegarth Healthcare Limited

Applegarth Nursing Home

Inspection report

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22 February 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 21 February 2018 and was unannounced. This meant that the provider and staff did not know we would be visiting. We carried out a further announced visit to the home on 22 February 2018 to complete the inspection.

Applegarth Nursing 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.

The home is registered to provide accommodation for up to 53 people with a variety of needs. There were 51people using the service at the time of our inspection. The home is divided into three areas: one providing care for frail elderly people, some of whom are living with dementia; one for people with neurological needs; and one for younger people with complex care needs.

At the last inspection of the home in July 2017, we rated the service as 'Good'. We carried out this inspection because we received concerns about the recruitment and roles of staff and care records.

At the time of this inspection the previous registered manager had retired. A new manager was appointed in December 2017 who had applied to be registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the provider had breached two regulations of the Health and Social Care Act 2008. The provider had not always followed safe recruitment practices when employing some members of staff. The provider's quality assurance systems were not always operated effectively to monitor the safety of the service and to ensure compliance with the regulations.

People felt safe and comfortable at the service. They felt staff used correct techniques when supporting them with care and when using equipment.

People and relatives felt there were enough staff to support the people who lived there. There was a good range of nurses and support staff on each unit and some people had one-to-one support.

Staff had the relevant training and support to care for people in the right way. The staff team were skilled and confident. Improvements were planned to how nurse competencies were evidenced.

Staff had a good understanding of the Mental Capacity Act 2005. 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.

People's health care needs were continually assessed, and their care was delivered in a way that met their individual needs. Staff were knowledgeable about people's individual care needs and how they wanted to be assisted. Any changes in their health needs were referred to the relevant health care services and the staff worked in collaboration with other health care professionals to support people's well-being.

People were supported to eat and drink enough. People who had special diets were not always offered choices about their meals. The provider improved this during the inspection.

People and relatives felt staff were caring and supportive. People were encouraged to make their own decisions and choices about their preferred daily lifestyle. Staff understood what was important to each person and were familiar with their preferences. There were warm and friendly interactions between people and staff. People had opportunities to join in activities or go out with staff.

People had information about how to make a complaint or comment and said these were acted upon. People and staff had confidence in the senior management team who all had specific roles in the running of the service. The provider had plans to redesign and upgrade the older part of the home in order to improve the accommodation and facilities for the people who lived in that unit.

You can see what action we told the provider to take at the back of the full version of the 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 always safe.

The provider's had not always followed safe recruitment procedures.

There was not sufficient storage for large pieces of mobility equipment so parts of the home were cluttered.

Medicines were safely managed but guidance records were an area for improvement.

There were sufficient staff to meet the needs of the people who lived there.

Is the service effective?

Good

The service was effective.

Staff were well trained to meet the specific needs of people although evidence of nurse competencies was an area for improvement.

Staff had a good understanding of people's rights and made sure they were not restricted unnecessarily, unless it was in their best interests.

People received good support with their health care needs.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were kind and friendly.

People were given time to go at their own pace and were not rushed when being assisted.

People were encouraged to make choices and be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their specific needs.

There was a range of activities for people to participate in to support their social care needs.

The service had a complaints procedure in place and people felt their comments were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's quality assurance system was not effective because it did not always identify systemic shortfalls.

People and staff said the management team was open and approachable.

People, relatives and staff felt they were asked for their views and could make suggestions about the service.

Applegarth Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 21 February 2018 and was unannounced. We carried out a short, announced visit on 22 February 2018 to conclude the inspection.

The inspection was carried out by three adult social care inspectors.

The inspection was prompted by concerns received by the Care Quality Commission. We also shared this information with the local authority. Before the inspection we reviewed information we held about the service. This included previous inspection reports and statutory notifications sent to us about the events and incidents that happened at the service. Notifications are changes, events or incidents the provider is legally required to let us know about.

During the inspection we spoke with seven people who used the service and two relatives who were visiting. We observed a lunchtime meal in a lounge. We observed how staff interacted with people as they went about their work.

We spoke with the provider's nominated individual, the manager, deputy manager, clinical manager, staff development manager, operations manager, a nurse, a clinical support worker, a lead health care assistant and three health care assistants, a cook, an activity staff and maintenance staff.

We looked at five people's care files and the medicine records for 20 people. We viewed the recruitment records of four staff, training records relating to all members of staff and quality monitoring reports.

Requires Improvement

Is the service safe?

Our findings

We carried out this responsive inspection after we received concerns that safe recruitment practices had not been used in the employment of some staff. We found a small number of staff were employed without an up to date Disclosure and Barring Service (DBS) check. DBS checks show whether applicants had a criminal record or were barred from working with vulnerable people so employers can make safe recruitment decisions.

In one case the provider stated they had made some practical arrangements to make sure a staff member did not have unsupervised access to people or their property, but there was no risk management plan to show how potential risks were controlled.

In addition a new staff member had unsupervised access to people using the service before the full disclosure was returned even though the DBS informed the home that there was an alert on the disclosure. The provider stated the person had been asked about the alert and had given an account of a minor conviction. However this discussion or outcome was not recorded on their personnel record. Also, there was no risk assessment about why it was deemed appropriate for this staff member to work alone until the full DBS was received.

In this way although some actions had been taken to assess the suitability of staff members these were not recorded so it was not demonstrable that people living at the home were protected from potential risk. At the time of the first inspection visit there was no risk assessment with identified control measures to make sure people were safeguarded from those potential risks. At the end inspection the provider had put in place a detailed risk assessment and said they would make arrangements for the supervision of newly appointed staff until full DBS checks were received.

We also noted that the provider's recruitment and selection procedures did not match the practices that were currently carried out whilst awaiting DBS checks for new staff. The provider confirmed that the procedures required review and this would be carried out by the senior management team.

We noted that a staff member was employed as a registered nurse support worker (that is, a senior care worker). However on the staff rota and in their personnel records it was not fully clear that the person was not being employed as a nurse. For example, the employment contract referred to both 'registered nurse support worker' and also 'registered nurse'. Their supervision record for the past two years referred to them as an 'efficient nurse' and 'a valued member of the nursing team'. There was a risk of confusion about the parameters of this person's role and the required clinical supervision within the home when they were on duty.

These matters were a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection we were able to enter the home via a main corridor where three bedrooms

were sited without any security checks by staff. This meant any visitors had unsupervised access to three people's bedrooms. This could compromise the safety and security of those people and also their privacy as one person, who was cared for in bed, chose to keep their door open. We raised this concern with the provider who arranged for the entrance door to be kept locked so access was only via a check by staff. We also discussed the anomaly of having three bedrooms in a main thoroughfare corridor between two locked units. The provider stated there were long-term proposals to upgrade the front unit of the home and the future use of these rooms could be considered at that time.

We looked at the arrangements for the safe keeping and storage people's weekly personal allowances and the number of staff who had access to these. We discussed with the provider how procedures could be strengthened to ensure safety and reduce vulnerability.

We looked at the management of medicines. Each person's medicines administration records (MARs) were kept together with their photograph and details of any allergies as well as the contact details for their doctor and supplying pharmacy. Medicines were stored in treatment rooms in each unit. The ambient temperature of the three treatment rooms was recorded daily and was found to be within the satisfactory temperature limits for medicines.

The majority of people's prescribed medicines were received from the pharmacy in colour-coded blister packs and some were provided in boxes. Blister packs were returned to the pharmacy every 28 days when new packs were received. We noted that where boxed medicines were not disposed of there was no record of the 'carried forward' amounts onto the next month's MARs. This would make it very difficult to audit any stock balances to check that the right amount of medicines had been administered or remained.

One person received covert medicines (that is, medicines disguised in food or drink) because it would be unsafe for them not to take them. There were clearly recorded decisions about whether the person had capacity to accept their medicines and the risks if they did not. However their care plan about being administered medicines covertly simply stated 'to be given in food/drink'. There was no guidance for staff about how this should be carried out, whether the medicines would be affected by heat or cold, nor what action to take in the event that the person did not eat or drink.

We found there were individual protocols for people who were prescribed 'when required' medicines. These included for example, medicines for occasional pain or episodes of agitation. At the last inspection we highlighted that these would benefit from containing more specific guidance, as per guidelines issued by the National Institute for Health and Care Excellence (NICE). However there was still little detail about when these might be administered for people who were unable to express themselves. For example, how people might present if they were in pain. Also some 'when required' medicines for agitation were prescribed in a variable dose, for example to be given either 0.5mg or 1mg. There was no guidance for staff about thresholds that would help them decide which dose to give. This meant people were at risk of receiving inconsistent support at those times.

We looked at the process for the application of prescribed creams and ointments. Most people using the service were prescribed topical medicines. The home had topical medicines application records (TMARs) in place and corresponding body maps to show staff where the creams should be applied. In most cases the creams were to be applied 'when required'. We saw the TMARs records were signed several times a day by staff even when they had not been applied. Against their name staff variably wrote 'NR' or 'NA' to show that the creams had not been applied. It was very difficult to determine from the long list of names when the creams had, in fact, been applied.

We looked at how medicines were monitored and checked to make sure they were being handled properly and that systems were safe. We found that whilst an audit was carried out weekly, it had not picked up the issues we found during the inspection. We considered that an effective monitoring system was not fully in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider employed a maintenance team who attended to general repairs, decoration and health and safety checks around the premises. There was a lot of equipment kept in corridors, including wheelchairs, hoists, shower beds and specialised seats. This may have presented a hazard. One bathroom in the older person's unit was open on the first day but was full of mobility equipment. This could have presented a hazard as people living with dementia may have accidentally entered this room. By the second visit the bathroom had been locked and was to be used only for storage.

We spoke with staff about the evacuation procedure. Some staff were more confident in explaining the procedure than others. We saw records that demonstrated when staff had taken part in fire drills and when they were next due.

The home was clean and personal protective equipment (such as aprons and gloves) was readily accessible. We did note that on two units there was an opened box of gloves on display in the corridor outside the lounges. The manager agreed this could compromise people's dignity and was unnecessary as there were boxes of gloves in each room and bathroom.

The people and relatives we spoke with said they felt safe at the home and with the support they received. One person said, "I use a hoist and I feel safe, I've never been dropped or felt unsafe. I'm safe and comfortable, it's what I like." Another person commented, "I'm well cared for and feel safe."

A relative told us, "I feel my family member is very safe here. I have no concerns and I've been very impressed with it, especially compared to some other places."

All staff had received training in safeguarding adults. The staff we spoke with said they understood their duty to report any concerns and were confident about doing this. For instance, a staff member said, "I've done my safeguarding training. I would report any concerns to the nurse such as any marks, if the person was withdrawn or not their usual self."

We saw the provider had safeguarding procedures in place in place and reported any concerns to the local authority, in line with local protocols.

Risks about people's individual health and safety were assessed, managed and reviewed. For example there were risk assessments in place for people who needed support to manage their medicines, skin integrity, nutrition, falls and mobility. There were risk assessments about the use of bedrails where people needed thee to stay safe in bed. There were risk assessments for some people where they required two staff to support them with all aspects of their daily living.

We spoke with staff about the management of any behaviour which was felt to be challenging. Staff told us they felt able to support people with these needs. One staff member commented, "We complete intervention logs and have done a course. I feel confident. We are all aware of the triggers and how to manage it."

People and their relatives felt there were sufficient staff to meet their needs and they were very visible

around the home. One person commented, "There's always plenty of staff around. I need two staff to support and they manage." A relative commented, "There's always a good amount of staff and they are very supportive of my [family member]."

A staff member said, "There's enough staff, we work in teams of two and have a routine for who does what." Another said, "It's normally the same staff (on each unit), it provides consistency but we will care on other units if needed."

The staff rota identified which staff members were allocated to each unit each day. There were between five to ten support staff, including team leads, on each unit as well as a nurse. In addition there were clinical support leads and activity staff who worked across the whole home. Around seven people required one-to-one care for most of the daytime and we saw there were sufficient staff to provide this.

Staff told us they thought the deployment of staff was right and where their skills were most useful. For example the nurse on the neuro unit had specific skills and training in relation to neurology care. A nurse told us, "We have specific nurses for each unit so we know the residents and their care plans." They added, "Yes we have enough staff, we sometimes also have an apprentice and sometimes a student nurse."

Some staff felt the home would benefit from an increase in activity staff (called life and leisure workers) as the two of them covered seven days a week across the whole home and they had a number of responsibilities, including risk assessments and record keeping, as well as activities and taking people out.

Good

Is the service effective?

Our findings

The provider employed a staff development manager who had begun to update a training matrix for all staff and had identified where staff required refresher training. The training matrix included essential training in health and safety subjects such as fire safety, safeguarding, moving and assisting and infection control. Staff also completed training that was specific to the needs of some people who used the service, for instance dementia awareness, non-abusive psychological and physical intervention and acquired brain injury training. Staff new to care were required to complete the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care.

During this inspection we noted there was no written evidence that nurses had been trained or assessed as competent in some nursing tasks. These included catheter care, tracheostomy and percutaneous endoscopic gastronomy (PEG). A PEG is passed into a person's stomach through the abdominal wall as a means of providing food and medicines when oral intake is not possible. Although nurses may have completed such training in the past there were no records in the home to confirm this. The nurses we spoke with said they felt competent and confident in these tasks. The staff development officer was able to show that there were plans to identify competencies of nurses and, where necessary, provide refresher training.

All the staff we spoke with felt supported with training and supervisions. One staff commented, "There's loads of training opportunities such as safeguarding, tissue viability, dementia, challenging behaviour - it's really good." Another staff member told us, "My induction was brilliant, I did moving and handling and using the hoist for different people. There was three days of training. I then shadowed another staff member so I could see how to care for each person."

Staff felt they were provided with training specific to people's individual needs. For instance one staff member said, "In induction and shadowing we were shown how specific equipment and suction machines, PEG machines and oxygen worked. It was scary but I'm confident now. They showed me what to do but said if I was nervous or didn't know what to do to get someone else and not to do it until I was confident."

Staff told us, and records confirmed, they had supervision sessions with a supervisor every couple of months. A nurse also told us, "We have clinical supervision for nurses and the lead care staff. We have a monthly theme, so this month its oral health and there's a little presentation and questionnaire and discussion points. It means we can discuss individual people's needs and make sure mouth care charts are completed."

People we spoke with commented positively on the quality and variety of meals. One person said, "I get what I want for meals. Staff cut my meals for me, but I would hate to be fed. I like to eat my dinner how I want to." One person said, "The food is good and you get a choice."

A staff member said, "We have pictorial and written menus. People chose what they want today for tomorrow. Not everyone remembers so we reminded people what they ordered but there are alternatives if they don't want it. Some people have pureed diets and it's pureed individually, its nice food, it looks

appetising."

On the first day of the inspection we noted that people who required a liquidised or pureed diet, due to swallowing difficulties, were only offered one option at mealtimes whereas other people had a range of options. We discussed this with the provider and by the second visit found that there were two liquidised meal options on the menu. We also noted that sometimes staff who physically supported people with their meal were unable to tell the person what the dish was. The provider agreed to discuss this with staff so that they could engage more with people during the meal.

We saw there were care plans in place about people who were at risk of poor nutritional health. Food and fluid logs and weight records were used to review the well-being of people and to check whether people needed additional support, such as fortified drinks and foods.

The home consisted of three separate units. The newer part of the building at the back of the home provided accommodation for people with neuro and complex care needs. In these units the corridors were wide, the lounges were spacious and there were specialist bathing and shower facilities for people with physical disabilities.

At the front of the home, which was the original and older part of the building, was the nursing unit which accommodated mainly older people some of whom were living with dementia. The corridors were narrow and it would be difficult to get more than a couple of people who used specialist chairs or wheelchairs in the small lounges. Some parts of this unit were dimly lit and there was no dementia-friendly orientation for people to find their way around. For instance, there were no picture signs for bathrooms and no contrasting coloured bedroom doors or memory boxes to distinguish different people's bedrooms. The provider agreed and stated there were proposed plans to completely redesign the unit.

We recommend that the provider considers recognised national guidance in dementia design when planning the proposed redesign of this unit.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS].

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had submitted DoLS applications to the local authority in line with legal requirements. We saw there were records of mental capacity assessments and best interest for decisions about any restrictive equipment such as bedrails. We also saw that staff respected people's rights to make their own decisions. For example, one person frequently declined support with nutrition but had capacity to decide this was upheld by staff. This meant people's safety and best interests were assessed in a way which did not compromise their rights.

People we spoke with felt they got "very good care". One person told us, "The care must be good because I'm much better than I was before I came here." People told us they were supported with any health care needs and were assisted with access to health care services. Care records contained details of referrals to other health care professionals. These included GPs, dietitian, speech and language therapists and tissue

viability nurses.

There was good collaboration between staff and other health care services. A nurse said, "We work with (external professional) and work well together. The acquired brain injury team are involved and put specific behaviour management plans in place and assess people's awareness levels looking at sensory needs so they implement sensory programmes. We look at rehabilitation to improve and maintain people's skills. Physios are involved and will do sessions with the care staff to keep people's movement going. Part of people's personal care is hand massage as it supports staff to minimise contractures."

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring and helpful. One person commented, "All the staff are lovely with me." Another person said, "I made the decision to move here and have never regretted it. Nothing is a bother, I can't knock the care and the girls (staff) are brilliant."

People told us they had very good relationships with staff. There was a sociable atmosphere in the home. People and staff spent time chatting and joking. People were visibly relaxed and comfortable with all staff. We observed staff supported people at their own pace and used low-arousal, soft voices and relaxed body language around people who may become agitated.

A staff member told us, "I think the care is great. We make relationships and get to know people and people get to know the staff. I know people are having the best time they can and are happy on a day to day basis. The family appreciate the care we provide. Everybody's happy – the patients, the families and the staff."

People and relatives said staff upheld people's dignity. One relative commented, "Staff always knock on the door, even though it's open, and ask my [family member's] permission before they come in or before they help her. They involve her in everything they are going to do."

People said they could choose who supported them. One person said, "I'm not bothered over male or female care staff but once I did ask if I could choose and they said 'yes absolutely'. There was one staff member I didn't want and my choice was respected."

People could choose where they spent their day and where they had meals. There were no dining rooms but dining tables were placed within some lounge areas. People could choose to have meals in their rooms, at the table or in their specialised chairs with a table brought up to them.

Although many of the people who lived at Applegarth had physical disabilities that restricted their lifestyle, staff encouraged their independence and promoted fulfilling daily activities. The life and leisure team were responsible for assessing the risk in relation to any activities. They said, "We aim to minimise any risk so people can have enjoyment. We look at positive risk taking, what is in their best interest and what's least restrictive."

People were encouraged to be involved in deciding on their own social activities and were supported to go out. A staff member told us, "People need to access the community and feel part of it, they shouldn't be isolated. I care about the residents; if they say they want something I try to put it in place."

People said they were able to lead their own referred lifestyle. For instance, one person said, "I like my little world the way it is. I like my routine. I get what support I need and I do the rest. It's about what I like to do. I will sometimes go to activities in a morning only. The option is there if I want to get involved but I'm happy, and they leave me alone to do my own thing."

We did notice that some people daily care logs were in the lounge areas so were available for anyone to read. One person's was left on top of the water cooler in a corridor. The provider commented that there was no confidential information the records but agreed that these should be stored away when not in use.

Good

Is the service responsive?

Our findings

The people we spoke with felt included and involved in decisions about the care service they received. Each person's care records included assessments about their individual needs, the level of support they required and their involvement in managing daily living tasks. Each person had care plans which set out guidance for staff about how to support them with their assessed needs.

The home provided care for people with a wide range of needs including support of people with life-limiting disabilities, dementia and mental health needs. The care records were written in a sensitive way that promoted each person's individual support needs.

Care plans were reviewed on a monthly basis and updated if there had been any changes. The review consisted only of a signature and date and did not reference any improvements or change in people's well-being. For example, a small number of people had been admitted to the home with significant pressure wounds. The treatment by home staff and tissue viability nursing services had improved these pressure areas, but the care plan review still reported 'no change'. In this way staff were not able to track the progress or decline of people's needs or goals over a period of time. The management team were receptive to advice about incorporating short monthly evaluations in care records to reflect the progress towards people's goals.

Staff were aware of people individual preferences and how to support them in a personalised way. For example, a staff described how they would support different people when they were upset or agitated. They told us, "For one person they enjoy the sensory room which calms them down, for another person it's about leaving and going back and trying again."

The life and leisure team (activities coordinators) were responsible for ensuring people were supported to follow their interests and take part in social activities. A member of the life and leisure team said, "People need to be fulfilled, I'm all for the residents they are my main priority. I get a picture of the social assessment with family and the resident and get people's background information. Some people have no one so it takes more time to build a picture of their likes and dislikes." They also told us, "I make sure there is something for everyone. I have a (activity) planner which changes with every season, and it's my role to make sure it happens. People like to go out so we take people out, sometimes as a group sometimes as a one to one."

People on the neuro unit were enjoying foot spas on one of the morning visits. We also observed a relaxation session which was led by a member of the life and leisure team and was held on the neuro unit but attended by people who lived in other areas of the home as well. The session was well attended by people, some of whom had one- to-one staff support. We observed the lighting was dimmed and the curtains closed to minimise distractions and support relaxation. Everyone present was included in the session, which involved the lead speaking to each person by name, showing them how they needed to breathe and supporting this by the use of appropriate touch.

People who were able to verbally share their experience of the session said they had enjoyed it and felt

relaxed. Their comments included, "I'm chilled out" "I enjoyed the music," and "I found it hard but I'm relaxed". Other people gave the thumbs up and some people's physical presentation was much calmer, quieter and relaxed. The life and leisure team member asked the staff present if they thought people had got anything out of the session and the staff were able to say how people had reacted to it. The session ended with a recap of the activities available over the week and people were asked to think about what they would like to plant in the garden or if there was anything else they wanted to do. In this way people were included in making decisions about their preferred future activities.

The activities timetable included support for people to do their own shopping, including on-line if they were unable or didn't want to go out. We were also told, "We are qualified to do keep fit with people, so safe chair-based exercises. Everyone loves it and all the residents were involved while we were observed and assessed."

We saw a staff member's dog was in the home and was being looked after by one of the people who was clearly enjoying the interaction and engagement. A staff member told us, "They all love her, she's hypoallergenic and really lovely to touch. She's very tactile for people. One person had been in the Household Cavalry Regiment and they loved their horse, so I brought mine in for them to see."

The provider had a procedure that set out how it would handle complaints. People were provided with written information that explained how to make a complaint if they were dissatisfied with the service they received. The provider kept a log of individual complaints and the actions taken to resolve them.

The people and relatives we spoke with said they would have no hesitation in raising any comments or complaints. One relative described a complaint they had made to the manager. They told us they felt listened to and they were very pleased with the way the complaint was resolved. They told us, "They took my comments seriously and made the improvement we wanted."

Requires Improvement

Is the service well-led?

Our findings

During this inspection we found the provider did not always operate effective systems to assess and manage risks relating to the safety of people who used its service.

Issues around staff recruitment, medicines records and organisational policies had not been identified by the home's quality assurance processes. Some records relating to staff did not accurately reflect their contracted title or the restrictions of their role. The security of the building and people's safety had been compromised by the open access into the building where bedrooms were sited.

Some of the provider's procedures did not match the actual practices taking place, for example recruitment processes. The provider's policy and procedure relating to the prevention and control of infection did not make reference to national guidelines (NICE). The management team had plans to review all policies and procedures.

Significant events, such as accident and falls, were coded and recorded on a spreadsheet. The complex system of codes made it very difficult to extract the details of a fall or accident and it was not possible without sourcing other archived records to identify what actions were taken. The manager agreed it was not currently possible to analyse accidents and falls to identify trends using the computer-based system. For example, trends about specific people at risk, environmental risks or times of day that may require more support. It also meant there was no demonstration that safeguards were put in place to minimise further incidents.

In this way, although the provider had quality monitoring processes in place, these were not always effective. These matters were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider kept a log of the safeguarding referrals it had made to the local authority in relation to incidents of alleged abuse. This was a monitoring tool which should have also prompted the provider to submit statutory notifications to the CCQ. A statutory notification is information about an incident or event that the provider is required by law to send. We saw that since the last inspection the provider had failed to ensure that statutory notifications were submitted in relation to five such incidents of potential abuse. This is a failure to notify and we are dealing with it outside of the inspection process.

Since the last inspection the previous registered manager had retired. A new manager was appointed in December 2017 and they had applied to Care Quality Commission to be the registered manager. Their application for registration was being processed at the time of this inspection.

The running of the home was supported by a management team, including skills development manager, quality compliance manager, operations manager and clinical support manager. We found the provider and management team were receptive to identified areas for improvement. The management team carried out a number of daily and weekly checks and audits including care plans, tissue viability risks, medicines check

and catering checks. In the sample we viewed shortfalls had been identified and these were signed off when corrective action had been taken.

There was clearly a culture in the home that was open to learning through mistakes. The home had a system of monitoring and checking the daily performance and record keeping by staff. Two clinical support assistants carried out the checks of daily care records and reported any 'non-conformities' for action and correction. The manager and provider felt this monitoring system supported staff to take responsibility for their performance and helped to embed good practices into their daily work.

People and relatives told us they had confidence in the management of the service and that the manager was approachable and listened to their views. One relative told us, "I feel the management act on things and they don't seem resistant to comments like some other places." Patient satisfaction survey were offered to a couple of people every month for continuous feedback. The most recent survey responses commented positively on the care service, the skilled staff and being involved in decisions.

All the staff we spoke with felt valued in their role. One staff member commented, "I enjoy it here. The staff and the residents are lovely, and it's a nice place to work. Everyone's supportive and approachable." Another staff member said, "I love it here. Problems are sorted out. It's a worthwhile job; I want to do it because it is worthwhile."

Staff felt guided and directed by the management and supervisory arrangements. One staff member said, "The nurses are a really good support and if there's an issue they will address it. I think they are stern but fair and good at their jobs."

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 The provider's quality monitoring systems were not effective in order to ensure the safety and quality of the service. Records relating to people, staff and the management of the service were not always accurately maintained. Regulation 17(1)(2)(a)(b)&(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider's recruitment process did not always demonstrate the suitability of staff or that necessary safeguards were put in place when employing staff. Regulation 19(2)(a)