St Philips Care Limited

Ridgeway Care Centre

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 22 and 23 March 2018. The inspection was unannounced. Ridgeway Care Centre is a care home providing accommodation, and personal care for people who live at the service. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ridgeway Care Centre accommodates up to 32 people. On the day of our inspection 28 people were using the service.

A registered manager was in post and they were available during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.
When we previously visited the service we found them to be in breach of regulation 11 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. This related to consent and following the principles of the Mental Capacity Act. At that inspection the service was rated as requires improvement. At this inspection we found evidence to show they were no longer in breach of this regulation. However, we found further breaches of the regulations.

People were not always protected from abuse, as although there were processes for staff to report any concerns they had, we found they had not always done this. The risks to people's safety were not always robustly assessed and information in people's care plans about the level of risk was not always correctly assessed. However staff were knowledgeable about people's individual risks and how to mitigate these.

People were not always supported in a timely way as recent changes in practice had affected staff deployment and this had been poorly coordinated by the management team. People's medicines were not always managed safely and efficiently.

The cleanliness of the service was, in general, maintained but there were some areas of kitchen cleaning practices that needed addressing. There was a lack of learning from incidences in some areas of care.

People's needs were assessed using nationally recognised assessment tools and staff had the skills to support them with their needs. Staff worked to ensure people had the freedom to express their choices and they were protected in line with the Equality Act.

Staff supported people with their nutritional needs and their relatives felt staff managed their health needs well. People lived in an environment that had been adapted to meet their needs and they were supported in line with the mental capacity act

We found staff caring and kind towards the people they supported and respected their views on their care.

However, staff did not always respect people's privacy and there were a number of occasions we noted staff did not knock on people's bedroom doors before entering.

Some information in people's care plans was not consistent, and the care plans did not all provide up to date information on the care people required.

The Accessible Information Standard for people was not always met. There was a lack of pictorial menus displayed for them and some people would have benefited from an easy read version of the company's complaints process being displayed.

Although some activities were provided for people at the service, there had been a lack of an activities coordinator over the previous three month. During our inspection we saw a large number of people lacked the stimulation of social activity.

The registered manager responded to complaints in line with their company's complaints policy and we saw this was displayed in the entrance of the service.

People were given the opportunity to discuss their end of life wishes.

There was a lack of consistent oversight of the service from the provider and this had resulted in ineffective quality monitoring. This related to medicines, care plans and environmental monitoring. A number of changes in senior management had resulted in a lack of support for, and oversight of the registered manager.

As a result of the above findings the provider was in breach of regulation 12 and 17 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014. This is the second time the service has been rated as Requires improvement. 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.

People were not always protected from abuse as staff did not always report safeguarding concerns raised to them.

The risks to people's safety were not always robustly or correctly assessed, however; staff had a good knowledge of people's needs.

People were not always supported in a timely way.

People's medicines were not always managed safely and efficiently.

Cleaning processes in some areas of the service were not always maintained.

There was a lack of learning from incidents in some areas of care.

Is the service effective?

Good

The service was effective.

People's needs were assessed using nationally recognised assessment tools.

Staff received appropriate training for their roles.

People's choices were protected in line with the equality act.

People's hydration, nutritional and health needs were supported and the environment they lived in had been adapted to meet their needs.

People were supported in line with the mental capacity act.

Is the service caring?

Good

The service was caring.

People's privacy was not always maintained by staff.

People were treated with kindness and their views and choices in relation to their care was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always contain consistent and up to date information on their care.

People were not always supported with appropriate social activities of their choice.

People's complaints were managed in line with the company's complaint policy.

The service did not always meet the accessible information standards.

People's end of life wishes were supported by staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager was a visible presence at the service and staff felt supported by them.

Some quality monitoring processes were not effective in identifying quality concerns related to people's care. This included auditing processes related to medicines, care plans, and cleanliness of some areas of the environment.

There was a lack of support for and oversight of the registered manager by the provider.

Ridgeway Care Centre

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 comprehensive inspection took place on the 22 and 23 March 2018 and was unannounced.

The inspection team consisted of one inspector and one Expert-by-Experience (EXE). This is a person who has had personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection, we reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about by law. We considered the last inspection report and information that had been sent to us by other agencies. We also contacted commissioners who had a contract with the service.

During the inspection, we spoke with ten people who used the service for their views about the service they received. We also used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with a visiting relative to gain their views. We spoke with the registered manager, the regional manager, two senior staff members, three care staff members, the activities coordinator and the cook.

We looked at the care records of five people who used the service. The management of medicines, staff training records, five staff recruitment files, as well as a range of records relating to the running of the service. This included audits and checks and the management of fire risks, policies and procedures, complaints and meeting records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at the service. One person said, "Yes I do feel safe here." A relative also said, "I am happy that [name] is safe here, yes." They went on to say, "I can tell you [relation] would not be in here if I wasn't happy with it. I know they check up on my relative during the night and record it, it makes [name] feel safe."

Staff we spoke told us they had received training in recognising safeguarding concerns and knew who to report these concerns to should they need to. They told us they could speak to the registered manager or report concerns to the CQC. However, we were made aware of a recent safeguarding concern that had been raised by a health professional. The registered manager told us as soon as they had been made aware of the concern they had undertaken an investigation. As part of this, they had become aware that the concern had been reported to a member of staff who had not acted upon the information. As a result the manager had undertaken individual supervision's with the relevant staff. They also arranged for all staff to undertake a safeguarding training refresher which they intended to go through at a staff group supervision.

The risks to people's safety were not always robustly assessed and information in people's care plans about the level of risk was not always correct. For example, one person's care plan stated they were at risk of falls and had fallen prior to their admission to the service. However, the person had fallen five times since their admission in October 2017. There was only one fall recorded in the person's care plan. The person had a fall risk assessment tool in place that had not been completed since October 2017. Some staff we spoke with were unaware of the number of times the person had fallen or what measures had been put in place to manage this aspect of their care.
The registered manager told us they had referred the person to the falls team and as a result the person had been given a walking frame to assist them when walking. We saw this information in the person's care plan, however there was no further information on how staff should monitor the person's mobility. The person preferred to spend all of their time in their own room and regularly moved about the room and en suite independently. There was no guidance for staff on how often they should check on the person to ensure their safety. This lack of information, and up to date assessment put the person at risk of receiving unsafe and inappropriate care.

We also found staff were not always recording information about aspects of people's care so the assessments tools could be used to accurately to assess their needs. For example, staff had completed a falls risk assessment for one person recording they had fallen every month for the last four months. This information was incorrect and indicated that staff had not actually undertaken an assessment each month but simply copied what had been written the month before. There was also information in the person's care plan stating they were not 'prone' to falls. As the person had an underlying health condition that could at times affect their mobility, the contradictory information did not give clear guidance for staff caring for this person. However, staff were able to discuss how they safely assisted this person with their mobility and we observed this to be the case.

We saw further information in this person's care plan in relation to the risk of skin breakdown and fluid

retention that affected their lower limbs. The person's care plan stated their legs should be raised when sitting in their chair. We saw when they moved to their chair after breakfast a staff member had ensured their legs were comfortably raised onto a stool. However, we later saw the person had been supported to the bathroom and then seated in another area and staff had not raised the person's legs as per the instructions in their care plan. We saw the person's legs were swollen and we raised the issue with the registered manager who told us they would address this. However the following day we saw the person was sitting for a long periods without their legs raised on a stool. This meant we were not assured staff were following guidance to reduce risks to people.

We discussed how staff would manage people's safety should there be a fire at the service and staff were aware of their roles during an evacuation. There was regular fire alarm testing at the service and the maintenance person tested and maintained fire safety equipment as part of their role. We saw records which showed regular servicing and maintenance of essential equipment was undertaken to maintain safe use.

People and relatives we spoke with did not express any concerns about the staff levels at the service. However, staff we spoke with told us that there were times when staffing levels did not meet the required needs of people they cared for. One member of staff said, "(We) always seem understaffed." They went on to say some changes in the way people were being monitored was causing some staff issues and had an effect on workload. Our observations showed that staff worked hard to meet people's needs, but they were at times under pressure to manage this needs in a timely way. We discussed this issue with the registered manager and the regional manager. The regional manager told us there were dependency tools the company used to establish staff levels. The registered manager was not aware of the tool so had not used this to establish the staff levels, but had worked on the company's standard staffing of one member of staff to seven people. This meant staffing levels were not based upon people's individual needs. The regional manager told us they would work with the registered manager to review staffing levels and ensure the established number met people's needs.

People could be assured the registered manager undertook safe recruitment processes when employing new staff to support them. The staff records we viewed showed a clear application and interview process, followed by references from previous employers. Gaps in employment were accounted for and the disclosure and barring service had been used to establish that prospective staff members did not have any criminal convictions that may affect the safety of the people they were caring for.

The management of people's medicines was not always safe. Whilst staff received training in safe handling of medicines our review of medicine records showed staff did not always follow safe practices when administering medicines. There were unexplained gaps on the medicine administration records (MAR) for individuals that meant we could not be sure people received their medicines as prescribed. There were no protocols in place for 'as required' medicines. We saw one person had three different prescribed medicines to be given 'as required' for one health condition. As there was no guidance in place for staff on which medicine was needed to manage particular symptoms we could not be sure the person received the most appropriate medicine to manage their condition.

Staff were also not consistently following medicine monitoring protocols the registered manager had put in place. The protocol had been put in place to highlight inconsistencies and ensure there was always medicines in stock for people. We found a recording error on one of the MAR sheets. The error had been made consistently over a period of a week, and had not been highlighted on the medicine monitoring protocol, or raised with the registered manager by staff or picked up on the registered manager's monthly audit.

The registered manager undertook a monthly audit which included reviewing half of all the MAR sheets. However this was the only audit of medicines at the service. This meant some inconsistencies and errors were not being identified and this put people at risk of continued inconsistent practice in relation to the management of their medicines.

People we spoke with felt cleanliness at the service was maintained and the majority of areas we viewed were clean. One relatives we spoke with said, "I think the cleanliness is fine; the rooms are always clean and tidy and the bedding changed regularly."

However we noted there were some concerns highlighted by staff at a staff meeting around the cleaning processes in the kitchen. This related to the lack of regular cleaning in the kitchen and that the storage of foods once opened was not being managed safely. Our observations showed this had not been addressed. There were some foods stored in fridges that had not been labelled, a lack of records to demonstrate regular temperature monitoring of fridges had been undertaken and a lack of cleaning schedules in place to show regular cleaning was conducted.

When we entered the kitchen there was a lack of personal protective equipment, such as aprons. We asked the cook for this equipment and also noted care staff were entering the kitchen without using this equipment. This meant staff practices could have a negative impact on the spread of infection at the service.

However, in other areas of the service, we saw personal protective equipment was available for staff to use when they required it, and we observed staff using the equipment when delivering care. Throughout the service we saw hand washing posters to remind people of the importance of good hand hygiene.

We discussed the cleaning schedules with the registered manager who told us there were schedules in place for peoples bedrooms but no cleaning schedules in place for the communal areas of the service. The cleaning at the service was monitored by undertaking completing a monthly infection control audit. We viewed this tool and found it was not detailed enough to monitor cleaning inconsistent and robust way. This lack of consistent monitoring of cleaning processes at the service could lead to inconsistent cleaning practices.

The above issues relating to management of risks to people's safety, staffing levels, infection control and medicines management are a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they have the potential to impact on people's safety and cause harm.

Although the manager did discuss issues of concern with staff they did not always have effective processes in place to show learning from past events. As a result areas such as medicines errors were not addressed robustly and lessons were not always learnt from this. Also since our inspection the registered manager made us aware of safeguarding issue. Although staff had raised the concerns to the registered manager they had not done so in a timely way. The registered manager had responded to the concerns in an appropriate way and was investigating both the incident and the timing of the response from staff. We discussed this with the registered manager and regional manager who assured us they were continuing to work on improving the processes for staff to learn from past events so improvements could be made on how care was provided for people.

Good

Is the service effective?

Our findings

People's needs were assessed using nationally recognised assessment tools and these tools formed the person's care plan. We saw some effective use of the assessment tools to manage aspects of people's care, for example, skin integrity. The provider had also recently implemented an electronic care plan recording system. Staff had been given hand held electronic devices that allowed them to record people's care as they provided it.

People were supported by staff to make their own choices in relation to how they wished to live their lives. Staff we spoke with told us one person expressed themselves in a way that could mean they could be discriminated against. However staff supported the person's diverse wishes and worked to ensure they were protected in line with the Equality Act.

People told us they felt staff had the skills to support them with their needs. One person said, "I think the staff are trained well and I know they have to do training for all sorts of things." A relative told us the staff used the hoist to move their loved one they said, "They seem to handle [name] in a safe and efficient way as far as I can tell."

Staff we spoke with told us they underwent regular online training. This covered areas such as health and safety, fire safety, dementia awareness and moving and handling. They were also supported with face to face practical training on moving and handling when they started in their role. Our observations of staff practice during the inspection showed staff used safe moving and handling techniques when assisting people in their care. Records showed the registered manager worked with staff to ensure they undertook regular training updates to support their practice.

People we spoke with told us the food at the service was good. One person said, "The food is excellent here and you can have as much as you want." Another person said, "The food is very good and we have a choice each day when (at meal times) they come and ask which we prefer."

Staff supported people with their nutritional needs. They were able to discuss people's dietary needs. When people required special diets due the risk of choking the registered manager had consulted the speech and language therapy (SALT) team to assess them for the most appropriate diet. This ensured people received the most appropriate diet for their needs. Staff knew whether meals needed to be puréed or fork mashable from the information provided by the SALT team's assessments. When required people had adapted crockery and cutlery to assist them when eating. Staff also told us they monitored the sugar intake of people who had a diabetic diet. One member of staff said they were aware it was individual people's choice to restrict their sugar intake but they always offered and encouraged a sugar free option for dessert at meal times and offered healthy snacks throughout the day.

People and their relatives felt staff met their health needs well. A relative said, "They have certainly kept me extremely well informed regarding GP and hospitals."

Staff we spoke with told us senior care staff responded to any concerns they had in relation to people's health. They were supported by the district nursing team and people's GP's. Staff were also aware of the measures they could take to keep people healthy. One member of staff talked about particular people's health needs. They were aware of the people who may be prone to urinary infections and that they needed to encourage fluids. They also discussed the people who needed to support and encouragement to walk. They told us it was important to maintain these actions to support people's health.

People lived in an environment that had been adapted to meet their needs. People had access to a number of communal living spaces and the lay out of the service allowed people to move around freely. The communal rooms were designed so people could either sit together and watch television in some areas or sit quietly in other areas. On the days of our inspection we saw people accessing the enclosed garden area, using the small room called the 'snug', the television lounges or sitting in the reception area. People could be assured the service was secure as there was a safe keypad entry and exit system to the home.

However, we found an issue related to a person's shower being faulty. It had not functioned since the person's admission a number of weeks ago. There was a maintenance person at the service, however, some repairs had to be approved by the company's regional office and the registered manager told us this had been raised to them. Our discussions with the person showed they were getting up very early (5.30am) so they could use a communal shower before it was needed for other people. We raised this with the registered manager who told us they would follow this up again with the regional office. Following our inspection the manager informed us the person's shower had been repaired and was in use.

When we last inspected the service we found the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, and was not always following the principles of the Mental Capacity Act 2005 (MCA). The 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.

During this inspection we saw the registered manager had made improvements to this area of practice. Where required the registered manager had undertaken some mental capacity assessments for some people and had identified other people who required these assessments. Staff we spoke with showed a basic understanding of the MCA and their role in supporting people to make their own decisions about their care. One member of staff told us they were aware some people in their care needed support to make their decisions and discussed how they do this. They said they simplified the way they asked things and used visual prompts to assist people.

People can only be deprived of their liberty to receive treatment and care 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). 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. We found any conditions specified were being met.

Good

Is the service caring?

Our findings

People told us the staff at the service were caring and empathetic. One person said, "You can't fault any of them. They are all very kind and caring." Another person said, "I am quite happy and well cared for, although only here a short while I know the staff have my best interest at heart and are kind and caring." A third person told us, "I have settled very well and they care for me so very well. I wouldn't dream of going anywhere else than here."

One relative we spoke with said they felt the staff were very kind and caring. They told us it was their relation's birthday recently, and the cook made them a cake and sang happy birthday to them. Relatives told us staff welcomed them when they visited the service and they had built up positive relationships with the staff who supported their loved ones. One relative told us they were able to visit whenever they wanted to.

Our observations supported these comments we saw a number of positive interactions between people and staff. For example, one resident required assistance with eating (as they sat almost doubled over) and a staff member was on their knees on the floor at the level appropriate to assist the person. The staff member was kind courteous and caring towards the person, allowing them to eat little and often at their own pace.

During the afternoon whilst we were sitting in a small sitting room with four residents chatting a staff member came in, a person asked if they could have a bath. The staff member dealt with their request straight away.

Some people we spoke with told us they were not aware of their care plans. However, a number of people were aware of the care plans and we saw evidence to show that both people and their relatives had been involved to creating their plans. For example, we saw one person and their relative had provided clear information on the person's preferences about their clothes, what support they required at meal times and where they preferred to spend their time.

The registered manager facilitated the support of an advocate when people required this service. Advocates support people who are unable to speak up for themselves. We saw there were posters in the service advertising the services of Advocates. We also saw one person as a requirement of their DoLS authorisation had been supported by an Independent Mental Capacity Advocacy (IMCA). IMCA's were introduced as part of the Mental Capacity Act 2005. They give people who have an impairment, injury or a disability, which results in them being unable to make a specific decision for themselves, the right to receive independent support and representation.

Whilst we saw some good examples of staff treating people with dignity throughout our inspection, we also saw that people's privacy was not always respected. For example on three occasions during our inspection when speaking with people in their rooms staff members entered the room without knocking. We also saw that one person's room was occasionally used to store other people's wheelchairs and when we entered the room to speak with a relative there was also a clean incontinence pad on the chair. We highlighted this

practice to the registered manager who told us they would address these issues with staff.

People we spoke with told us they were supported to be as independent as they could be. One person said, "I like to be as independent as I can and I manage my own tablets, make my own bed and do as much as I can for myself still."

We saw some people at the service were able to go out independently as the home was situated near a main shopping area. Staff we spoke with were aware of the importance of allowing people to be independent. We observed staff supporting and encouraging one person who was able to slowly walk short distances. They did this with care and patience.

Requires Improvement

Is the service responsive?

Our findings

When we last visited the service we found the care plans did not always contain clear guidance on the care people required. During this visit, whilst we saw the registered manager had addressed some of the issues, not all the care plans we viewed had consistent and up to date information on the care people required. For example, one person had lost a significant amount of weight since coming to the service. There had been a consistent weight loss each month of approximately 2.5kg over the previous eight month. The person's care plan did not give any information about this weight loss and it appeared from the care plan the weight loss had not been monitored. The monthly evaluations in the person's care plan did not mention the weight loss. One member of staff we spoke with was unaware of this weight loss and told us the person was a 'good eater'. We spoke with the registered manager who told us the person's weight loss had been monitored and had been discussed with the person's GP. They told us, as the person had a high body mass index and was eating a healthy diet the GP felt the weight loss was beneficial to the person. However, staff lacked of knowledge of the gradual weight loss. In addition, the lack of information or guidance in the person's care plan on how much weight the GP felt was a safe and healthy weight loss meant there was a danger that the continued weight loss would cease to be beneficial to the person.

There was also a lack of guidance for one person who displayed particular behaviours at times. Their care plan did give staff guidance on triggers for these behaviours and how they should support the person, but there was no guidance on how they should record the person's behaviours.Staff told us the person continued to display particular behaviours at times. However we were only able to find one incomplete observation sheet in the person's care record.

We also found staff were not adding essential information in the monthly evaluations of the care plans or updating assessments to reflect the changes in people's care. For example, one person had fallen three times in one month between January and February 2018, but the evaluation section of their falls care plan noted they had fallen once in that month. Their falls assessment had not been up dated since September 2017 and their mobility plan did not contain any information on their recent falls. However, staff we spoke with were aware of the person's falls and how they needed to support them. A member of staff told us the person sometimes tried to walk without their frame so they needed to remind the person and ensure it was always within reach. This lack of information placed people at risk of inconsistent support.

Staff we spoke with told us they did not always get the time to read the care plans. One member of staff said, "Sorry I don't (read care plans) it's difficult time wise. But I always try to read information for new people." Staff felt the communication on people's day-to-day needs had improved and daily handovers gave them good information about people's care. One member of staff told us they also regularly talked to one another informally about changes in people's care needs. Our conversations with staff showed the majority of the time they did have a good knowledge of people's care needs to offer them the support they needed.

We checked to see if the service was meeting it duties under The Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss. We saw whilst there were some good examples of accessible

information for people. For example, signage around the home appeared good, there was a lack of information on the meals available for people. There were no pictorial menus displayed for people and on the day of our inspection the written menu did not match the choices available. People were asked at mealtimes what their preferences were, but staff did not show sample-plated meals as visual aids to assist decision-making. One person told us, "We don't know what's for lunch, we never do, it just comes." This meant if people did not want the meals on offer they would have to wait whilst an alternative was sourced for them.

People told us until recently there had been a range of activities available for them such as dominoes or board games, but this was no longer happening. One relative said, "There's not much stimulation for [name] they just sit down and sleep. There used to be things happening."

Staff told us there had not been an activities co-ordinator in post for the previous three months. However, we saw a new activities co-ordinator had been employed the week of our visit. During our visit we saw the activities co-ordinator spent a lot of their time in one lounge with a small number of people who lived with advanced dementia. There were no activities offered to a large number of people. One person said, "We don't seem to do things (social activities) now. This one (activities co-ordinator) has only just started so its early days. The other manager used to take us out but it hasn't happened yet with this one."

Some people told us they preferred to stay in their own rooms and one person told us they had been able to have their own computer in their room. They said, "I can keep in touch with the world and my relative in particular through that (computer)." However, they went on to say, "I would love to get out more, but it's difficult – and I can't expect everything."

Another person told us their relative came daily to take them out for lunch or coffee and shopping. They said, "I like to get out." They told us they spent most of their time in their room as they liked their television programmes. They said, "My room is lovely and I prefer it up here."

People told us they were aware of how to make a complaint should they need to. One person told us, "I have no complaints but the ladies (staff) would sort it if I had any niggles." A relative told us they had had concerns, but they went straight to the manager and got things sorted out. They felt the manager was responsive to their concerns.

Staff we spoke with were aware of how they should manage any complaints made to them. One staff member said they would always try to sort any small issues straight away, but would record any concerns they could deal with and escalate to the registered manager so this could be dealt with to people's satisfaction. The registered manager told us they had not had any formal complaints since being in post and worked to deal with issues as they arose so both people and their relatives were happy.

There was a complaints procedure displayed at the service in the entrance. However, some people at the service would have benefited from an easy read format which was not available. We raised this with the registered manager who told us they would address this.

Where people had wished, their end of life care was documented in their care plans and staff we spoke with told us they worked with people, their families and relevant health professionals to make sure people were supported to have a comfortable, dignified and pain-free death.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had not been consistently supported in their role by the senior management team and this lack of support was reflected in the way the quality of the service was monitored.

Whilst areas such as falls, care plans and medicines were being audited, the audits were not highlighting issues such as poor and inconsistent information in care plans. This inconsistent information in people's plans affected the information in areas such as falls that was being collected monthly and sent to the provider. The way medicines were monitored meant that medicines errors were not being identified consistently. This had a negative effect on the quality of the service people received.

The service did not have cleaning schedules in place for some areas and the environmental audit that was completed each month lack sufficient information to show that areas were being consistently audited. The registered manager told us they and the maintenance person undertook a regular walk around the service and identified when areas required attention. However, there were no records of the walk arounds, and the registered manager had not completed any action plans to show what work had been carried out and who was responsible for completing the work. This meant some areas of concern could be over looked or not monitored robustly, such as, the continuing concerns related to the quality monitoring in the kitchen.

Over the last year the registered manager had been supported by three different senior managers. During this time the senior managers had not had consistent oversight of the quality monitoring processes at the service. During our visit we spoke with the regional manager who had joined the provider in November 2017 and been recently given responsibility for the service. They told us they were in the process of introducing a quality monitoring system for the company that would pick up concerns we highlighted and they felt would make the auditing process more robust. They accepted the concerns we raised about the quality monitoring of the service.

Staff we spoke with told us there had been some staff meetings over the last few months. We saw minutes of two meetings, one in October 2017 and one in March 2018 approximately two weeks prior to our visit. We saw during the October 2017 meeting the issue of staff not reviewing care plans robustly had been raised as an area for improvement. However there was no indication of who would monitor this or who was responsible for undertaking the reviews. This meant staff did not know who was accountable for ensuring these improvements.

The registered manager also told us there had been a staff survey undertaken in October 2017. The completed questionnaires had been sent to the company's head office for analysis but there had been no feedback on the results of the questionnaires. This meant while staff had been asked for their views they had received no information on how their views had been used by the company going forward.

People and their relatives told us they were not aware of any resident and relative meetings and we were only able to find minutes for two meetings in May and October 2017. The minutes showed there was no agenda and the meeting showed the registered manager had asked questions about staff attitude what

activities were available and the progress of the refurbishment of the service. People also told us they had not completed any questionnaires about their views of the service. We asked the registered manager if people at the service had been consulted in relation to choice of the decoration and refurbishments. They told us the choices of colour schemes and refurbishments had been decided at head office and neither people nor staff had been invited to offer an opinion. This showed a lack of engagement of people's views by the provider on the environment they lived in.

This lack of quality monitoring and lack of engagement with people and staff at the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

The service had a registered manager in post on the day of our inspection. It is a condition of the service's registration to have a manager who is registered with the CQC. The registered manager was clear about their responsibilities, they had notified us of significant events in the service and the last CQC inspection rating was displayed in the home. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

People and their relatives told us the registered manager was visible and approachable. The manager's office was by the entrance of the service and we saw when people came in they stopped to chat to the registered manager and the service administrator.

Staff we spoke with told us the registered manager was supportive and, overall, they were happy with the way the service was run. However some staff did find the way the rosters were managed difficult as they often did not know what shifts they were working until a week prior to the shifts.

Staff were supported with supervisions four times a year where issues of concern and wellbeing could be discussed. The registered manager had a programme in place and although one or two staff members were showing as not receiving a supervision session within the last three months, the manager was aware and was working to address this.

The registered manager told us they used these sessions to ensure staff were aware of their responsibilities in their roles. Staff we spoke with told us the sessions were helpful as they were able to highlight any areas they felt they needed support or training in. They told us they felt they were listened to.

During our inspection we saw staff were using a new electronic care record system. This had recently been introduced and staff had hand held electronic devices that allowed them to enter information on care as they delivered it. Both the registered manager and regional manager were hoping this would improve the recording of a number of aspects of people's care. Such as the recording of falls, fluid management and management of skin integrity. This would then make information gathering more robust and help them analyse and improve the care people received.

The registered manager told us they worked with external key organisations to improve the care people received. For example, the district nursing team supported the service and the registered manager worked to have a good relationship with the team. They had discussed the nurses coming to offer training for staff. The registered manager also attended local manager forums run by the local authority and had gained knowledge of the development of local initiatives to improve multidisciplinary working.

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of clear up to-date risk assessments in place, staffing levels did not always meet the needs of people at the service, medicines were not always managed safely and infection control measures were not always followed by staff at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Some quality monitoring processes were not effective in identifying quality concerns related to people'S care. This included auditing processes related to medicines, care plans, and cleanliness of some areas of the environment. There was also lack of support for and oversight of the registered manager by the provider.