Magna Cura Limited

# St Michaels

## Inspection report

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13 January 2017

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The inspection took place on 11 and 13 January 2017 and was unannounced. St Michael's is a residential home for up to 45 people who have a variety of support needs, such as older people and people with a physical or sensory disability. There were 36 people living at the service at the time of the inspection.

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

At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There were not always enough staff as communal areas were often left unattended and situations were not monitored which left people at risk. Staff told us they felt more staff were needed. Some people told us they felt more staff were needed, however some people were satisfied.

Plans were not always in place to support people if they became agitated. Staff were also not trained to support people effectively who were experiencing periods of agitation.

Risk assessments and detailed plans were not always in place to try and prevent people from falling and if people had fallen. Action had not always been taken to support people from falling again and some people had continued to experience falls.

Medication Administration Records (MARs) had not always recorded whether people had had their topical medicines and PRN protocols were not always in place for people that had medicine that was to be taken 'when required'.

All safeguarding allegations should be reported to the local safeguarding authority however we found an instance of one allegation that had not been reported. Other safeguarding incidents had been correctly reported to the local safeguarding authority.

The principles of the Mental Capacity Act 2005 (MCA) had not always been followed. Assessments had not always been carried out to help determine if people were still able to make decisions and if they could what type of decisions. Evidence of Lasting Power of Attorney (LPOA) had not been consistently sought and those who did have an LPOA did not always have the correct one in place regarding health and welfare.

Care plans were not always personalised and did not always contain full information about people and their

preferences. Staff were sometimes used from an agency and new staff started periodically. This put some people at risk of not having their needs met or not having their preferences catered for as there was limited information available for them.

Audits of accidents and incidents or care plans had not been taking place so omissions had not been identified. Medicine audits were in place however these had not identified concerns relating to topical medicines.

Although there were occasional events for people to attend, overall people told us they were bored and there was not enough for people to do and they were not always supported to partake in hobbies.

People told us they felt safe and their relatives confirmed they felt their loved ones were safe in the home.

People felt staff were caring and that they were treated with dignity and respect. People had the choice of where they spent their time and were supported to maintain their privacy.

Safe recruitment practices were in place and staff had appropriate checks prior to starting work to ensure they were suitable to work with people who use the service.

People had access to other health professionals in order to maintain their health and wellbeing.

People were supported to have food and drinks of their choice that were appropriate for their needs.

People and relatives were encouraged to provide feedback or complain if they needed to and it was felt that this feedback was acted upon.

Staff felt supported and that they could approach the registered manager. There was an open door policy and staff all said they could raise concerns if necessary.

Staff and relatives knew who the manager was and felt able to go to them with queries. The manager had also been submitting notifications about the service, which they are required to do.

The registered manager had also arranged home managers meetings, establishing a local network of managers who could share best practice.

## 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.

Staff were not deployed safely as communal areas were often left unattended and some people felt there were not enough staff.

People did not always have their topical medicine as prescribed.

The majority of incidents, apart from one, had been reported correctly to the local safeguarding authority.

Safe recruitment practices were followed to ensure staff were working with people who used the service were fit and of good character.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Staff had not been trained sufficiently to support people effectively.

The principles of the Mental Capacity Act 2005 were not always being followed. Capacity assessments were not always carried out and Lasting Power of Attorney's were not always checked.

People had adequate amounts of food and their preferences and needs were catered for.

People had access to health care services and were supported by staff where required.

### Is the service caring?

**Good**

The service was caring.

Privacy and dignity was respected. Staff were comforting when necessary.

Staff offered choices and respected those choices.

People were able to spend their time where they chose to and had personalised surroundings.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People were not consistently supported to undertake activities of their choice.

People did not always have personalised care plans or their preferences documented.

The service had a complaints policy, and people knew how to complain.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

Action had not always been taken to rectify issues when people had experienced behaviour that challenges.

There was a lack of oversight regarding accidents and incidents.

There were minimal quality monitoring systems in place to ensure care files were fit for purpose and the administration of topical medicines were poorly documented.

People, relatives and staff all felt supported by the manager and they had confidence in them.

The registered manager felt supported by the provider.

# St Michaels

**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 11 and 13 January 2017 and was unannounced. The inspection was carried out by one inspector and accompanied by 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. This was the service's first inspection since it's registration.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services.

We spoke with 12 people who use the service, six relatives, four members of staff that supported people, the registered manager, the deputy manager and six professionals that have contact with the people who use the service. We also made observations in communal areas. We reviewed the care plans and other care records for seven people who use the service and at the medicine records for seven people. We also looked at management records such as quality audits. We looked at recruitment files and training records for three members of staff.

Requires Improvement

# Is the service safe?

## Our findings

Although some people told us that there were enough staff to meet people's needs, some people told us and we saw that there were not enough staff. One person we spoke with said, "They need more staff here, it's not fair on the ones that work hard. They do their best" and another told us, "There is not enough staff. Sometimes I have to wait in the night." Another person we spoke with said, "Sometimes staff are busy but you accept things." A member of staff we spoke with said, "There's not enough staff. They [the people living there] are all individuals and they like things done in a certain way so there's not enough of us." Another member of staff told us, "There's not enough staff, we need at least an extra member of staff in the morning." A relative also told us "If I ring up on any matter the telephone call is rarely answered." Feedback from relatives was that it can sometimes take a long time for the front door to be answered. One relative said, "A friend of my relative's rang the bell repeatedly, waited and waited and nobody opened the door." We also saw in minutes from meetings with relatives that the door not being opened had been raised. We observed that communal areas often had no staff in them to check on people. One person also told us, "No staff come in this lounge, they don't come in to check on us." People had to wait for support if they needed help to stand up and walk or transfer to a wheelchair. One relative told us, "Today I arrived at 11.30am and my relative was still sitting at the breakfast table waiting to be moved. Sometimes I arrive between 2.30pm-3.00pm and if they're not in their bedroom I find them still sitting alone in the dining room waiting to be brought back. Sometimes if staff are running late in a morning they don't take my relative to the dining room but they make them some toast in the upstairs lounge." We also observed the person sitting in the dining room alone waiting for staff to support them after people who could walk unaided had left. This meant that although some people did not have to wait for support, those who needed more support were sometimes left waiting and communal areas were not supervised so incidents could have continued to occur due to a lack of staff presence to defuse situations, when necessary.

Whilst we were present, another altercation occurred between two people, whereby one person hit another. No staff were present in the communal area when the altercation occurred. Another person pressed their buzzer and a member of staff came into the room and moved one of the people to another seat so they were separated. The member of staff then left the room again. Staff had not been trained to know how to manage people's behaviours that may challenge and some people needed extra support to help them manage their behaviour. If incorrect techniques are used, it could cause a situation to escalate or if restraint was required to protect a people or staff and staff were not trained then it could result in an injury to both the person or the member of staff. By having effective training in place to manage challenging behaviour it would help staff reduce the incidents between people who use the service. The person's plan stated that staff should be aware of the person's whereabouts at all time and for staff to remain vigilant in communal areas. However, there were also many occasions when staff were not present so they would not be aware when the person was becoming agitated. This meant there was a risk to people and staff health, safety and wellbeing.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient plans in place to inform staff in how to support the person who hit another person to become less agitated and how to de-escalate the situation. One relative who visited regularly told us, "I have seen altercations here in the lounge between one person and other residents; [the person] targets people. Usually nobody sits in the chairs by [the person] as they lash out." When we asked the registered manager they told us that there were no plans in place for staff to follow, that staff were "just to observe [person's name]". We saw multiple incidents documented involving the person who needed support to manage their behaviour when they became agitated. There were no documented actions regarding how the likelihood of future incidents occurring could be reduced or how staff supported the person to become less agitated. This meant that the person, staff and other people had their health, safety and wellbeing put at risk due to there being insufficient plans for staff to follow to protect the person and de-escalate the situation when the person became agitated.

Some people were at risk of falling; however plans and risk assessments in place lacked detail as to how people should be supported to prevent them from falling. For people that had fallen, there was often no action documented as to how the likelihood of future falls occurring were reduced so people had continued to experience falls. For example, one person had had five falls in three months. Their first two falls resulted in them being taken to hospital however there was no evidence to suggest any preventative action had been taken and the person had subsequently fallen a further three times. Another person had fallen six times within two months, the third fall resulted in them sustaining an injury and visiting hospital. There was insufficient action documented following this fall and the person had fallen a further three times. Another person had experienced three falls within a four week period and the home referred the person to the Falls Prevention Team in order to reduce the likelihood of another falls occurring. A relative we spoke with said, "Recently my relative had a fall, I thought they seemed alright but the staff were very thorough and took them to the GP to be checked out." Therefore people were not being consistently protected and there was a risk to their health, safety and wellbeing.

People told us they had their medicines. One person we spoke with said, "I always get them [medicines], they come and remind me." One relative we spoke with said, "I think my mother is safe here and receives her medication." Documentation relating to medicines that were ingested, such as tablets or liquids, showed that staff were clearly recording when tablet medicine had been given or refused. However, documentation relating to topical creams showed that staff were not recording if creams were being applied or offered. For example, one person is prescribed cream to be applied on one part of their body three times a day and the documentation showed it had only been applied on 13 occasions out of 93 in total. Another person who also required cream to be applied twice a day only had it documented that it had been applied on 22 occasions out of 62. This person was at risk of having skin integrity issues so if cream was not applied as prescribed there was a risk of pressure sores developing. There were no explanations recorded as to why the cream hadn't been applied or whether it had been offered and refused by the people. This meant people were at risk of harm as the provider could not be sure people received their prescribed topical cream.

Some medicine is applied or taken as and when required, called 'PRN medicine'. Protocols should be in place for staff to follow so they can identify when a person should take their medicine and what the guidance is around taking that particular PRN medicine. Some people may not be able to tell staff if they needed their PRN medicine as they lacked capacity. There were no protocols available to help staff identify when a person may need or not need their PRN medicine. This meant there was a risk of some people not always getting their PRN medicines when they needed them and their symptoms persisting.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw documented an incident whereby a person hit another person who both live in the home which had not been reported to the local safeguarding authority. As the incident had not been reported we could not be sure that appropriate action was taken to keep people safe from future incidents. All safeguarding incidents must be reported to the local safeguarding authority to investigate and one of these had not been. Staff we spoke with were able to identify abuse and they knew how to report it. We saw evidence of other safeguarding incidents which had been reported in the correct way. However, incidents may have continued to occur due to the local safeguarding authority not always being made aware of incidents as they were not reported.

We observed staff administering medicines and they were kind and encouraging to people. People were not rushed and were given their medicines at their own pace. We checked the storage, documentation and the stock levels of some medicines. They were stored safely and the stock levels matched the documentation. Oxygen cylinders were also stored correctly as they were chained to the wall. Other medicines that needed to be refrigerated were stored in a refrigerator that was at the correct temperature was checked regularly to ensure it was within the correct temperature range. The rooms where medicines were kept were also checked to ensure they were below the recommended maximum temperature. This meant people were supported to take their non-topical medicines at their own pace and medicines were kept in line with guidance.

Some people needed extra support to help them mobilise. We saw a person being assisted from a sitting down to a standing position and then sitting down in a wheelchair by two members of staff. The staff used the correct support techniques and ensured the person's feet placed on footplates when sitting in the wheelchair. Footplates ensure the person's feet don't drag on the floor and cause injury. We also saw staff making sure people had their personal walking aids to support them.
People told us they felt safe. One person we spoke with said, "There is always someone around I can go to." A relative we spoke with said, "I feel very comfortable leaving my relative here." Another relative told us, and another relative told us, "I feel my relative is safe living here." One professional we spoke with said, "People feel well looked after, we speak to residents." Another professional we spoke with said, "Yes I think they are safe, the staff know who people are and where they are." This meant that people were living where they felt safe and supported by staff.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with people who used the service. Agency staff had also been checked for their suitability to work. This meant that people were supported by staff who were suitable to work with the people who used the service.

There were checks in place in relation to building safety such as fire equipment checks, checks on electric and gas supplies as well as equipment used by people. There were also plans in place in the event of an emergency such as a fire, and each person's level of support required to evacuate the building, if necessary, had been identified.

Requires Improvement

# Is the service effective?

## Our findings

Staff told us they had the training when they started working at the home, and were supported to refresh their training, which was both online and face-to-face and we saw records to confirm this. However, staff would have benefitted from training in how to support people when they became anxious and on occasions aggressive. This training would help staff to care for people safely. A member of agency staff we spoke with also confirmed they had an induction on their first day working in the home. This means that mandatory training had been completed and staff were supported to refresh this.

Staff felt supported in their role to effectively care for people. There were no documented supervisions however staff told us they felt supported. One member of staff said, "If I've got any problems I can always go to the seniors." Another member of staff said, "We work well together as a team" and another said, "I feel supported, if there is something on my mind I can go to the manager. They tell me to go to them." This meant staff felt they had the support they needed to work effectively and to continue to care for people.

The MCA 2005 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. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. A person who has LPOA for financial decisions cannot make decisions regarding health and welfare.

We saw evidence that LPOA had been considered by the service and saw some evidence of LPOAs in people's files. However, some of these LPOAs were for financial decisions so they are unable to make decisions regarding the person's health and welfare. This was not clear in people's plans and could lead to LPOAs making the wrong decision on people's behalf. In some instances, copies or evidence that a LPOA was in place were not available so it could not be verified whether representatives had the right to make decisions on people's behalf. This meant people were not always protected as people who may not have had the legal right to make decisions had been recorded as able to make these decisions.

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). In order for staff to know whether a person no longer has their capacity and whether a DoLS referral is appropriate, a mental capacity assessment should be carried out to help them determine the type of decisions a person can make. Multiple referrals had been made, however people did not always have capacity assessments in place. Therefore it was not possible to determine how the service established that a DoLS referral was required and whether the person had capacity to decide about where they chose to live. This meant that although some appropriate applications had been made, people who had a DoLS in place had not been assessed sufficiently.

Staff told us they had received training regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and records also showed that some staff had undertaken this training but staff were not always able to tell us about the MCA, although some could. People told us they were able to choose when they were supported. For example, two different people said to us, "I get up when I want" and, "I get up and go to bed when I want." Another person told us, "You can have a bath or a shower when you want." One member of staff said, "People can make their own decisions." We also saw people were offered choices throughout the day, such as where they would like to spend their time and what food they would like to eat and drink.

People were supported to maintain their nutritional intake and most people told us they were happy with the food. One person we spoke with said, "The food is very nice" and another person told us, "The food is good." Another person we spoke with said, "The food is not too bad. The cook is very good; she visits me daily and asks if there is anything I fancy to eat." We saw staff offering a range of drinks during lunch time. We observed staff offering people different foods at breakfast. One person we spoke with said, "I can ask for something else if I don't want what's available." One person who had specific dietary needs told us, "I have a dietary need and the staff bend over backwards to get special food in. The cook who is in today is marvellous." We observed people at lunch time having food appropriate for their dietary needs, and the food was well presented and people could ask for more. Another person also told us, "If I wake in the night they make me a hot drink and a snack." This meant people were offered a choice of food and had food and drink appropriate to their needs and at a time suitable for them.

We saw that other health professionals had been involved with people's care when necessary. One person we spoke with told us, "My keyworker is also very good. They get the GP when I need it" and another person told us, "I see the doctor when I'm unwell." Another person said, "If I need a doctor they call them out." Whilst we were at the service, a GP had been contacted as someone had been unwell in the morning. There were also visiting professionals we spoke with. One professional told us, "I have a good relationship with the service. They mention things when I am here if needed." We saw records involving podiatrists, continence services, opticians and appointments at the hospital. People were weighed regularly in order to check they remained healthy and were not unintentionally losing weight. One person had been losing weight and had been weighed regularly, this weight loss had been identified and a referral made to the GP. This meant people were being supported to access other health professionals to help maintain their wellbeing.

Good

# Is the service caring?

## Our findings

People told us they were happy living in the home. One person we spoke with said, "We're all happy here. I've been here for 6 months. I've got a nice room." Another person we spoke with said, "I am happy here, it is ok. I have a nice room with my own things." Another person told us, "From day one the care has been fantastic, the staff are marvellous." We also overheard someone say, "They are a nice carer they are, they have a lovely face and they smile." One relative we spoke with said, "It's like a home from home." We observed notices around the home encouraging people to decorate their own rooms and bring in personal items to make people feel more at home. One person was also able to bring a musical instrument with them so they could continue with their playing, as they would have done at home. People were also able to have visitors at times that suited them. One person told us, "Visitors can come anytime" and a relative told us, "I have been visiting most days for a while, I can visit anytime." This meant people were supported to maintain their relationships with their loved ones at a time that was convenient to them and had the comfort of their own personal items and décor in their personal spaces.

People and relatives told us and we observed staff treating people in a dignified manner. One person told us, "Staff explain things." One relative we spoke with said, "They [the staff] treat my relative with dignity. They treat them humanely. They're friendly with them and very good." We saw staff member crouch or sit down to be at the same level as the person so they could see the member of staff's face whilst they were talking. We observed one person who became upset and confused. A member of staff came to sit with them and held their hand and comforted them and talked to them about things the person enjoyed until they were less upset. One member of staff we spoke with said, "I try to treat people how I treat my own grandparents." A member of agency staff we spoke with told us, "It is the best home I have been in. They don't rush anybody and don't force people to do things."

People could choose where to spend their time and were given privacy. Some people chose to spend time in their bedroom or in the communal lounges. One person we spoke with said, "I'm quite independent. I go down to the communal room when I want." A person we spoke with told us, "I prefer to stay in my room" and another person we spoke with said, "You can lock yourself in your room. My relative found this place, it's marvellous. We are being looked after." Another person told us, "I can lock my bedroom door from inside." When a person was being supported with their medicine, they were encouraged to go into a private room and a visiting professional we spoke with said, "People are given privacy for medical appointments." This meant people could retain their privacy and had options of where they could spend their time.

Requires Improvement

# Is the service responsive?

## Our findings

People and relatives told us there was not enough to do. One person we spoke with said, "There are no activities, this is it, we just sit here with the TV on. If they gave us a choice we would take part. It's just so boring here." We overheard a person speaking and they said, "I was bored, that's why I slept." And they went on to tell us, "We don't do anything. There's nowhere to go and nothing to do." Another person we spoke to said, "Occasionally there is karaoke but not very often as only one carer will do it. We celebrated, St Patrick's and St Georges Day and the Queen's birthday." A relative we spoke with said, "Nothing happens here in the way of activities, no motivation, I don't believe the home meets the social needs of the residents." One member of staff we spoke with said, "There could be more activities." Another member of staff said, "Time isn't available to support people with activities." We did not see any activities taking place on the days we were inspecting. We observed people sitting in the lounges and would often fall asleep and there were no staff present to encourage people to partake in hobbies. There was a large room with a large table and unused gym equipment that would have accommodated a large number of people to partake in group activities however it was unused by people and only used to store mobility equipment when it was not being used. A cinema room had also been developed with a large screen however there were not many chairs and we saw no people used this room. We asked the registered manager about activities and they told us that there was an exercise class which people enjoyed. One relative told us, "I don't think any activities take place although I have seen some exercises done sometimes on Monday; otherwise they all just watch TV." Another relative told us, "There used to be an exercise class on a Monday that was very good, the residents became very motivated but I haven't seen the class happening for a while." The lack of hobbies for people to partake in could have an effect on their mental health and people's social needs were not always met. The registered manager told us of plans for one of the care staff to come in once a week to spend the day doing activities with people and we saw posters around the home informing people of this. This meant that people were not receiving care that reflected their individual preferences in relation to hobbies and activities and was not ensuring people's needs were met.

People were supported to come into the dining room at the same time. However, everyone had to wait for all people to be seated in the dining room before being served their food which meant some people had to wait a long time. On one day of the inspection people were seated by 1pm however the food was not served until 1.40pm.On the other day of our inspection one person commented, "How long have we got to sit here?" whilst they were in the dining room waiting for their lunch. People were all seated by 1.10pm but the food was again not served until 1.40pm. After the main course had been finished, some people started chanting, "Where's our pudding? Where's our pudding?" as they had been waiting. People were becoming frustrated with having to wait for their food. This meant that people were not receiving care that reflected their individual needs.

Despite some permanent staff knowing people well, care plans were not always detailed and people's involvement in their plan of care was not evident. The service was using some agency staff at times who would not always know the people living in the home. Two people's care plans stated 'Staff to be aware of [person's name] likes and dislikes' however these were not recorded anywhere. One person we spoke with

said, "If any staff can't come in they get agency staff. Some agency staff are better than others" and another said, "There are lots of agency staff who I can't understand and they can't understand me." A relative we spoke with told us, "I think my relative may be forgotten because they are in their room, especially by agency staff who don't know anything about my relative." Another relative we spoke with said, "There are a lot of agency staff although it has not been so bad recently." The lack of detail in care plans put people at risk of not receiving personalised care that met their individual needs and reflected their preferences, particularly from new or agency staff.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The poster about how to complain was not in an area that most people would access and did not provide the contact details of those who could be complained to. One relative did say, "I don't know the complaints procedure but would soon find out if I needed to." However, most people did know how to complain and felt able to. One person we spoke with said, "I can always go to someone if I've got any issues, but I've never had to raise anything though." Another person told us, "I've not had to make a complaint but I know how to" and another said, "I have no complaints." One relative we spoke with said, "The manager appreciates my feedback and I like that". We saw that when complaints had been made they had been recorded and written responses sent in line with their policy. This meant that most people knew how to complain and felt able to, and the service responded to complaints when they were received.

There were meetings held with people and relatives. One person we spoke with said, "We have residents meetings about every 3 months, where you can bring things up, they listen to you and make some changes. It's all written down by a carer and then shown to the manager." One relative we spoke with said, "I've been invited to a relatives meeting" and another told us, "There are few relatives meetings but if there is one there is a notice on the wall in the entrance hall." Another relative also said to us, "I don't have to wait for a meeting, I can knock on the office door, it's always open." We saw the notes from these meetings and feedback had been acted upon. For example, people's feedback that it would be preferable if staff wore aprons and had their hair tied back when serving lunch and we saw that staff were doing this. There was also a meeting which discussed the idea of a food tasting session and we saw this took place and the kitchen staff made a range of dishes for people to try and people voted on them. This meant people and their relatives were encouraged to offer their opinions and changes were made based on people's feedback.

Requires Improvement

# Is the service well-led?

## Our findings

When people had fallen there was no analysis of any patterns or trends to try and determine why a person or people were falling or if something could be done to reduce the likelihood of a person falling again. There was also a lack of detail as to what action had been taken or there was no action documented to help people to stop falling in the future. When we asked the registered manager about this, they explained that all falls and incidents were logged on their system; however they had not been analysing them so trends had not been identified and it had not been identified that action was not always taken following a fall. The registered manager said, "I've missed things" in relation to the auditing of accidents and incidents. This meant that risks were not being monitored and there were not always mitigating actions in place relating to health, safety and welfare of people. There was a safeguarding incident that had not been reported to the local safeguarding authority which had not been identified by the registered manager as audits of care notes had not taken place. This lack of analysis and oversight may have contributed to why people had continued to experience some falls or incidents within the home.

There was no evidence of audits of care notes and care documentation and therefore omissions had not always been identified. For example one person had fallen and their risk assessment or care plan had not been updated to reflect their change in needs and due to audits of records not taking place this had not been identified as an omission. Another person's care documentation had limited detail in relation to how staff could support them to manage their behaviour and become less agitated. People's care planning documentation had limited or no detail on people's preferences which had not been identified. We found that this impacted on the way people were being cared for and their individual needs and preferences were not always being met. For example, there was a lack of hobbies and interests available for people to partake in and a person was not always being supported safely by staff when they were agitated. This meant there was not always an accurate and complete record for each person and that improvements had not been made based on audits, as these had not been carried out.

Staff had not always received the training necessary to effectively support people, which left people and staff at risk. Although it had been identified that staff were not able to support a person effectively with behaviour that challenged, no action had been taken to train staff to support people who did experience periods of agitation. This left people and staff's health, safety and wellbeing at risk. This meant that the systems the provider had in place to monitor and improve the service were not always effective.

Medicines audits had been carried out on occasion however they had not identified concerns relating to topical creams and the poor recording and that people were at risk of not always receiving their topical medicine as prescribed. There were also no PRN protocols available for staff to follow and this had not been identified. We asked the management team about the PRN protocols and they said, "They must have been removed from the MAR chart folders and filed away." However they were not able to show us these. Staff would have needed daily access to these documents to help them determine if someone needed their medicine, if they were unable to tell them if they needed it. People may not always have been receiving care in a way that met their needs.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicines audits on medicine other than topical creams had identified concerns, such as when staff had not signed to say whether they had administered a medicine or not. Action had been documented to indicate the staff involved had been informed about this and when we looked at MAR charts, the recording had improved. This meant that although some audits were in place for non-topical medicines other audits for topical medicines and the plans of care were not in place and omissions had been overlooked.

People, relatives and professionals all knew who the registered manager was and all told us how approachable they were. One person we spoke with said, "I speak to the manager whenever I want to. They're very good, they explain everything to me." Another person said, "I see the manager and I can chat to them." Another person also said, "I know the manager and the deputy, they stop and have a chat when they pass by my room." One relative told us, "I looked at other homes but chose this one as I was impressed with the manager's values and way they work." There was an 'open door' culture and people, staff and relatives all told us they could go to the registered manager whenever they needed to. A relative said, "The manager is good, I have a laugh and a joke with them and if I have any problem, they listen and they deal with it within the day." Another relative said, "I see the manager and can talk to them whenever I like, I've seen the manager in the lounges as well." Another relative also told us, "I see the manager around the building and can go to the office at any time." One professional we spoke with said, "The registered manager is about quite a lot and the deputy is supportive." Another professional we spoke with said, "The manager's attitude is very good. They are passionate about caring for people." This meant people and relatives were able to speak to the registered manager at a time suitable for them and felt confident their feedback would be acted upon.

Staff also felt supported by the registered manager. One member of staff said, "The manager tells me to go to them." We saw that staff meetings were held which discussed updates and passed on learning. For example, it had been discussed that people come down for breakfast at different times and that people shouldn't wait for everyone to be up to have breakfast. We observed at breakfast that people were served as they came into the dining room rather than having to wait. We also saw evidence that health and safety had been discussed so that people did not trip on walking aids, they were moved into another room whilst people were eating in the dining room and we saw this being carried out and given back to people when they wanted to leave the dining area. We also saw that learning following a safeguarding incident had been discussed with staff in order to try and prevent a reoccurrence.

The registered manager had established meetings with other home managers in the local area in order to share best practice, to learn and have a support network. Guest speakers had attended on a variety of subjects such as DoLS and recruitment. This meant the registered manager was trying to learn and improve and also help other homes learn and improve also. The manager had also notified CQC about significant events that they are required to notify us of by law.

The registered manager told us they felt supported by the provider, they said, "I can ring them whenever", they went on to tell us and they have supervisions with the provider. A relative also told us, "Even the owners are good, they saw me out and about and came to speak to me and knew my relative's name." We saw that regular meetings were held between the registered manager and the provider and action was taken following feedback.

Since our inspection the registered manager sent us an action plan which detailed how they were going to improve and also details of what action they had already taken. This meant that although there were

concerns identified, the registered manager had listened to feedback and had taken steps to rectify omissions.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People were not always supported to partake in hobbies or interests. Care plans did not always detail people's preferences and people did not appear to be involved with their care plans. People were not supported in a manner responsive to their individual needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Plans were not in place for staff to follow if people were experiencing periods of agitation. Action had not always been taken when people had fallen to reduce the likelihood of them falling again. Risk assessments lacked detail. Topical medicines were not always being administered in line with the prescription. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Analysis of accidents and incidents was not taking place so trends were not identified. Audits of care plans and associated documentation were not taking place. Medicine audits had not incorporated topical medicines so concerns were missed. |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were often not present in communal areas so there was a lack of oversight when incidents occurred. Some people and staff felt there were not enough staff and people with higher mobility needs sometimes had to wait for support.