Wellburn Care Homes Limited

Eighton Lodge Residential Care Home

Inspection report

Low Eighton
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 October 2016 and was unannounced. We had last inspected Eighton Lodge Residential Care Home in February 2015 and found breaches of legal requirements in relation to managing medicines and training for staff. At this inspection we found the provider had made improvements in these areas, though the medicines arrangements had not been closely monitored.

Eighton Lodge Residential Care Home provides personal care and accommodation for up to 47 older people, including people with dementia-related conditions. At the time of our inspection there were 34 people living at the home.

The service had a registered manager. 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.

We found there were hazards resulting from work being carried out in the building which compromised people's safety. These hazards had not been recognised and no efforts were made to control the risks until we brought them to the attention of the management. We highlighted further potential risks including a lack of diligence in making sure domestic equipment, and in one instance a cleaning chemical, were safely stored to prevent the likelihood of harm occurring.

There were established processes for protecting people from abuse and responding to any safeguarding concerns. Risks to people's welfare had been assessed and measures were in place to safely provide individual care and support.

Any new staff were properly checked and vetted before they started working at the home. Sufficient staff were employed to ensure people were provided with consistent care and staffing levels were kept under review. Training provision had been improved to equip staff with the necessary skills to care for people effectively. Regular supervision and annual appraisals were carried out to assess performance and support staff in their personal development.

People were supported to access healthcare services to maintain their health and well-being. A varied diet was offered to aid good nutrition and when necessary, dietetic advice was obtained. People told us they enjoyed the food. We have made a recommendation about the way staff are deployed at mealtimes to make sure people are properly supervised.

People's rights under mental capacity law were protected and formal processes were undertaken when people were unable to make important decisions about their care. People and their representatives were consulted about care and treatment and advocacy services could be arranged if needed.

Staff sought permission before providing support and encouraged people to make choices in their daily living. They were caring in their approach and respected people's privacy and dignity. People and their relatives spoke highly of the care provided. There was a clear complaints procedure in place if anyone was unhappy with the service they received.

Care was appropriately planned, tailored to people's individual needs and preferences, and adapted in response to any changes. People were offered a good range of social activities, entertainment and opportunities to out into the local and wider community.

The service had a registered manager who was supported in their role and provided leadership to the staff. Methods of seeking feedback about the service were being improved upon. Systems for monitoring standards in the home had not identified the shortfalls we found during the inspection. The quality and safety of the service needed to be kept under closer scrutiny.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the safety and governance of the service. You can see what action we told the provider to take at the back of the full version of this 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 consistently safe.

Risks associated with hazards in the environment and safe working practices were not sufficiently well-managed to keep people safe at all times.

Medicines arrangements had improved, though there had been a lack of robust oversight in identifying shortfalls and ensuring improvements were sustained.

Steps were taken to safeguard people against the risk of abuse.

Enough staff were employed to safely meet people's needs.

Is the service effective?

Good

The service was effective.

Training had been improved to equip staff with the necessary skills to care for people effectively.

People's rights under the Mental Capacity Act 2005 were understood and upheld.

People were suitably supported in meeting their health care and nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring, engaged with people and had developed good relationships with them and their families.

People were supported to make day-to-day choices about their care.

Staff treated people with respect and promoted their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care planning was personalised to people's needs, routines and preferences.

A good level of activities, events and outings was provided for stimulation and to help people meet their social needs.

People and their families were made aware of the provider's complaints procedure. No complaints had been raised about the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems for monitoring and improving the quality and safety of the service, and reducing risks, were not fully effective.

A registered manager was in post who provided leadership to the staff team. Morale was good and staff felt well supported.

The home had an open culture and further efforts were being made to obtain feedback and work inclusively with people and their relatives.

Eighton Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We checked if improvements to meet legal requirements had been made following our last inspection in February 2015.

This inspection took place on 10 and 11 October 2016 and was unannounced. The inspection team consisted of an adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority commissioners of the service.

During the inspection we talked with six people living at the home, four relatives and observed how staff interacted with and supported people, including during mealtimes. We spoke with the deputy operations manager, the registered manager, the deputy manager and seven care and ancillary staff. We reviewed six people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We checked the action taken in response to the breach in legal requirements about medicines management that we had found at our last inspection. The registered manager informed us the poor practice witnessed at that visit had resulted in disciplinary action being taken. Staff responsible for handling medicines had received further training and had their competency assessed at six monthly intervals. Records confirmed this and the assessments included a test of knowledge and observing that staff administered medicines according to the home's procedures.

Arrangements were in place for the secure storage of medicines and a new alarm had been fitted to the treatment room door. Medicines were ordered monthly and most were supplied in blister packs with the time of day they were to be given. We observed an error had occurred whereby the pharmacy had supplied a medicine meant to be given at night, in the teatime blister pack for a person. This time was also indicated on the accompanying pre-printed medicine administration record (MAR) provided by the pharmacy. The error had not been picked up on at the home and the person, whilst coming to no harm, had consistently been given the medicine at the wrong time. The deputy manager confirmed the pharmacy had not supplied another person's medicines on time and that they had been unavailable for a period of two days. The registered manager followed up on these issues with the pharmacy during our inspection.

Records relating to medicines were of a variable standard. Care plans had been revised to ensure staff had sufficient information about people's individual medicines regimes, though some plans were not fully up to date. Suitable care plans were recorded where a person's usual medicines had been discontinued and anticipatory medicines prescribed, and for a person who received their medicines covertly (disguised in food or drink). Records had been introduced to clearly show where on the body topical medicines (creams and ointments) were to be applied. We noted at times that staff had entered incorrect codes to the MARs when topical medicines and inhalers were refused or not given for another reason. Some of the MARs did not have photographs to help staff identify the right person when giving medicines. The majority of MARs had been appropriately completed and confirmed people had received their medicines at the times they required them. Some gaps in the MARs were evident, where staff had omitted to sign confirming administration, though checks of the supplies showed the medicines had been given.

Overall, whilst improvements had been made to the management of medicines, the discrepancies we found had not been identified by the management or staff. We have therefore required the provider to make improved governance arrangements which more effectively monitor the quality and safety of the service that people receive.

Regular checks and audits were conducted into the cleanliness and maintenance of the home, fire safety, facilities and equipment. However, during our visits we observed a number of issues which could compromise people's safety. A planned refurbishment to upgrade areas of the home was being completed in stages. Works in the corridor leading off from the reception area and in the office doorway had been left incomplete, and the management did not know when the contractors were due to return. Both areas had uneven floor surfaces which posed trip hazards and the corridor, in particular, was a main thoroughfare

used by people with mobility difficulties, staff and visitors.

The carpet on the upper floor corridor was rucked in places and presented a potential trip hazard. A vacuum cleaner and a carpet cleaning machine had been left unattended on the ground floor corridor where someone might fall over them. The registered manager reported there was a general lack of storage space in the building, though could not confirm if this was being addressed as part of the refurbishment plans. We noted two unoccupied bedrooms and the hairdressing room were being used for storage and these rooms were kept locked. Radiator guards were in the process of being replaced. One person's bedroom door was not closing fully, meaning it was not safe in the event of a fire. Although staff had been trained in Control of Substances Hazardous to Health Regulations, we observed a cleaning chemical was left unattended on the dining room windowsill during lunch. This was a bottle of brightly coloured multi-surface cleaner, labelled 'exotic fruits'. We removed the bottle to prevent anyone accessing it or mistaking it for a drink which could cause harm if consumed.

Immediate remedial action was taken when we highlighted the safety-related matters to the registered manager and staff. However, we concluded that the provider had not done all that was reasonably practicable to reduce risks to people's safety within the environment.

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

People and their relatives described feeling safe at the home and being treated well by the staff. Their comments included, "They (staff) are all first class and really try to help. You couldn't ask for better staff and I feel safe here", "My mother is very safe here", "She's kept very safe. I have peace of mind and confidence in the staff" and "They put a sensor in place after she had a fall."

Systems were in place for safeguarding people against the risk of abuse and for responding to any alleged abuse. Some safeguarding information was displayed in the home for people and their visitors to refer to. The guide to the service was also being updated to include information for people about their rights to be protected from abuse. All staff had been trained in and had access to safeguarding and whistleblowing (exposing poor practice) procedures. The registered manager and staff we spoke with understood their responsibilities in reporting any concerns or suspicions of abuse. No safeguarding concerns had been raised about the service over the past year.

A 'duty of candour' policy had been introduced. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. The registered manager informed us the policy was planned to be discussed at a forthcoming meeting with staff to raise their awareness.

We reviewed the safekeeping of people's personal finances. Individual care plans were in place for the support people required in managing their finances. These included, where applicable, the involvement of appointed representatives, such as relatives with power of attorney for financial affairs. Suitable records were kept of the money held on behalf of people and any purchases made. All transactions were witnessed, countersigned and receipts were obtained. Weekly checks of cash and balances were conducted which the registered manager agreed would be recorded in future. Monthly audits were carried out as part of the provider's quality process to ensure people's money was being handled safely.

Areas of risk to personal safety had been assessed and ways of minimising risks were built into care plans. These included measures to guide staff on safely supporting people with aspects of their care including

moving and handling, falls, nutrition and maintaining skin integrity. Practical measures were also taken such as the provision of handling equipment, sensor mats to alert staff to movement, and pressure-relieving aids. We observed that staff supported people with mobility difficulties using safe moving and handling techniques. Any accidents and incidents were appropriately reported and recorded and we were told a more meaningful analysis of these was being introduced.

Recruitment records showed that a robust process was followed to check the suitability of new staff. All necessary pre-employment checks were carried out, including obtaining proof of identity and references, completion of application forms, interviews and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups.

Staffing numbers were calculated on a monthly basis, using a tool that assessed occupancy and people's dependency levels. At the time of the inspection these were six care staff during the day, five in the evenings and four at night, including team leaders on all shifts. The registered manager's hours and a proportion of the deputy manager's hours were in addition to these numbers. Separate staff were employed for activities, catering, housekeeping, laundry, bed-making and maintenance duties.

The registered manager reported the home had a full complement of care staff. Cover for absence was provided by bank staff or from within the team to ensure people received continuity of care. External agency staff were not used at the home. The registered manager and deputy manager operated an on-call system that enabled staff to get advice or support and to escalate any emergency circumstances to senior management.

Detailed information was made available to staff in case of emergencies. This included contingency plans for the service, key contacts and an individual plan to maintain each person's safety if they needed to be evacuated from the home. The registered manager told us the service was looking to introduce the 'Herbert Protocol', a national scheme whereby vital information is completed to assist police should a vulnerable person go missing.

Good

Is the service effective?

Our findings

We checked if the provider had taken action in response to the breach in legal requirements about staff training that we had found at our last inspection. The deputy manager told us improved systems had been introduced to provide and monitor that staff had undertaken mandatory training at the intervals set by the provider. All training was delivered in a combination of face-to-face courses and through training DVD's with accompanying knowledge tests.

New care staff were given induction training to prepare them for their roles and were expected to complete the 'Care Certificate'. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

The service maintained a matrix giving an overview of all training completed by the staff team and training certificates were kept on staff files. This showed a substantial amount of training had been completed in safe working practices such as fire safety, moving and handling, health and safety, infection control and food hygiene. Further topics of training had been provided in line with the needs of people living at the home. These included dementia awareness, continence promotion, and caring for people at the end of their lives. The management team had identified 'care champions' to promote particular areas of care, including falls prevention, skin integrity and diabetes. Lead roles were assigned according to staff's skills and interests and advanced training had been arranged. The majority of care staff had also either achieved or were working towards nationally recognised qualifications in care. We concluded that the provider had made the necessary improvements to ensure staff were adequately trained in meeting people's needs.

There was a delegated system for providing staff with individual supervision six times a year and annual appraisals. This was confirmed in staff records and monitored by the deputy operations manager. Those staff we talked with were happy with how they were supported in their personal development. One staff member commented, "We all get plenty of training and support."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that the service worked within the principles of the MCA and relevant policies and procedures were available for guidance. Staff had been trained in the MCA and DoLS and understood people were not always able to give consent or make their own decisions about their care. This was reflected in care records which captured details of the individual's communication methods, levels of understanding and the support they required. Formal processes had been followed to carry out mental capacity assessments and, where applicable, make decisions in a person's best interests. The decisions addressed care-related issues, including where people were resistant to intervention, the use of aids and equipment for safety, and administering medicines.

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). A number of people living at the home had DoLS authorised to enable them to receive the care and treatment they needed. We were informed further DoLS applications were being submitted to the local authority.

Relatives we talked with were happy that their family members received effective care. They told us, "No doubt about it, this place is good. We are happy with the way decisions are made and the staff discuss treatment with us" and "They do take good care of her. She's improved and gained weight."

Staff of all grades had received training in nutrition and diet. Nutritional needs were assessed using a screening tool that identified if people were malnourished or at risk of malnutrition. People were weighed regularly and, where necessary, food and fluid intake were monitored. Dietetic advice was sought and some people were prescribed nutritional supplements. Any support needed with meeting dietary requirements and/or assistance with eating and drinking was set out in care plans. For instance, one person, who was frail and unable to communicate verbally, had a care plan that guided staff on all aspects of their needs. These included ensuring they were positioned correctly to eat, providing a soft, high calorie diet, and for help to be given with all meals and drinks. It also informed staff they particularly liked chocolate and fruit juice and how to detect from facial expressions if the person was not happy with the food they were being given.

The home had been given a five star food hygiene rating by the local authority. There was a four week varied menu with choices at each meal and alternatives could be readily prepared if requested. Drinks and snacks, including biscuits and prepared fruit were served between meals. Information about people's individual dietary needs and preferences had been gathered and passed onto the catering staff. The cook confirmed they were kept up to date with any changes or weight loss and said they routinely fortified food and provided calorific drinks such as milkshakes and fruit smoothies. They told us they did lots of home baking and aimed to keep people satisfied. We noted at lunchtime that staff offered soup or sandwiches, though we clarified with the cook that sufficient quantities were prepared and people should have been asked if they wanted both options. The people we talked with gave positive comments about the quality of the food, telling us, "The food here is lovely", "I like the food" and "I always have a good breakfast", though one person said, "The food is sometimes cold."

Relatives said they were kept updated about any issues affecting their family member's health. They told us, "If anything happens they deal with it and let me know", "If she needs a doctor they are called out straight away" and "We are always kept informed." One relative felt their family member needed input from a physiotherapist and the registered manager confirmed this had been arranged.

We saw that information was obtained about people's medical history, current conditions and health care professionals involved in their care. People were supported to access a full range of health care services, including GP's, district nurses and psychiatric services. All visits from, or contact with external professionals was documented, including details of any treatment and advice provided. Health needs were detailed in care plans and future decisions about resuscitation and people's wishes regarding their end of life care and treatment were documented. Summaries of health and care needs were also being developed to enable people's care to be co-ordinated in the event of admission into hospital.

The deputy operations manager told us the electronic care planning system was being customised to link mental capacity issues to each area of care planning. The system was also planned to be adapted to enable reports to be run, such as checks on people's health progress.

Good

Is the service caring?

Our findings

People living at the home told us, "They (staff) are very caring and always look after me" and "They're lovely and go out of their way to help you. I think they're absolutely marvellous and have a lot of patience with me. If I've any problems I know the staff will sort them out."

Relatives spoke well of the caring nature of the staff and the standard of care provided. Their comments included, "The staff are friendly and my mother is well cared for" and "I'm very happy with the treatment she gets and am impressed by the way they help."

One relative told us they had viewed many care homes and made a number of visits to Eighton Lodge before making the decision for their family member to move in. They said they had been given plenty of information during this time, had all their questions answered and told us, "We made the right decision. I'm so happy." Another relative also told us they had researched a number of different homes, visiting them and seeking the opinions of others. They said, "This seemed to be the best one and I'm very happy." The hairdresser, who had been coming to the home for a number of years, told us they had got to know people and felt the care and the staff were good.

During our visits we saw that staff were polite and respectful towards people and showed a caring attitude. For instance, they handled situations where people's actions might be harmful to themselves or others in a sensitive and patient way. Where people were unable to tell us about their care, we observed they were relaxed in the company of staff and responded positively when they engaged with them. A frailer person, who was cared for in bed, looked comfortable, well cared for and had the necessary aids for their safety and comfort.

At lunchtime we observed that staff provided support in a dignified way, sitting with those people who needed direct assistance with eating and drinking. Aprons to protect clothing from spills and paper serviettes were made available and aids to help people eat independently were provided. The start of lunch on our first visit was somewhat delayed and the mealtime was not well organised. People were seated for around 20 minutes, with staff serving both hot and cold drinks, before food arrived to be served. One person was restless during this time, putting their serviette into a cup of tea and we intervened as they were about to put it in their mouth. On our second visit the mealtime was better organised and food was served promptly. People were offered choices and extra portions. We did however note that a person dining in a part of the main lounge struggled with their food and ended up being helped by another person they were sitting with. This went unnoticed by staff as they were not present in the area during the meal.

We recommend that the service reviews the way staff are deployed at mealtimes to ensure people are adequately supervised.

Staff had been trained in person-centred care, equality and diversity, and the principles underpinning good care. As part of the supervision process, two sessions each year now involved supervisors observing the staff member's care practice, including checking that they interacted appropriately with people and maintained

confidentiality. Some staff had recently been designated lead roles for championing the rights of people with dementia and dignity in care. They were undertaking further training to support their responsibilities, which included embedding important values into everyday practice and enhancing the care provided at the home.

The staff we talked with had sound knowledge and understanding of people's needs and vulnerabilities. Our observations confirmed that they knew people well and, where needed, the best approaches to take with individuals to gain their co-operation. Good relationships had also been formed with families and we saw staff greeted visitors, spent time talking and offered them refreshments. One relative told us, "The staff are lovely, really caring and I'm very satisfied."

We observed that staff were mindful of seeking permission before giving support, took time to explain what they were doing and did not rush people. Routines were flexible and we saw some people had chosen to get up later in the morning and were having a late breakfast. One person told us about other choices they made in relation to their preferences for meals and drinks and said these were accommodated by the staff. Details of routines, including the times people liked to get up and go to bed, were documented in care plans to make staff aware of their preferences. Practical ways of preserving people's dignity whilst being supported with personal care and how individuals preferred their care to be given were also built into care plans for guidance.

We saw staff completed an 'induction checklist' when a new person moved into the home. This covered providing a welcome pack of information, offering keys to their bedroom and lockable furniture for privacy, being shown how to use call system and introduced to other people. A range of information was also provided and displayed for people and their families to inform them about what was happening in the home and support from other agencies. This included photographs and details about staff with different roles, the complaints procedure, advocacy services, social activities and the hairdressing service. Information on care-related issues was also made available, such as leaflets about dementia, decision-making and deprivation of liberty safeguards.

The registered manager told us that, wherever possible, people and/or their representatives were encouraged to be involved in planning and reviewing care. A relative confirmed this and commented, "I visit almost every day and see that the care in practice is what I was told she would be given." Advocacy services could be arranged if a person did not have family or friends to represent their views.

Good

Is the service responsive?

Our findings

The people and relatives we talked with told us staff were attentive and responded to their needs and requests. Their comments included, "The team leader said to me they were there for me if I ever need anything", "You can approach any member of staff or the management if you have any concerns", "The staff are responsive and caring", "Staff have even helped us with benefit forms" and, "They (staff) have time to spend with the residents."

Care records showed assessments were completed before people were admitted to make sure their needs could be met at the home. Assessments were also obtained, where applicable, from the person's social worker. There was evidence in one person's records of how staff had responded to concerns about their skin condition upon admission, by contacting the district nursing service. Further assessments were routinely updated to ensure each person's current needs were identified. The information gathered from assessments had been used to develop individual care plans for each identified need.

The care plans we reviewed addressed all aspects of personal care, physical and mental health, mobility, eating and drinking, communication, and social needs. They were nicely personalised, giving details of the extent of care and support the person required, what they could do independently, and how they wished to be supported. Where the person was unable to give information about their background and preferences, relatives had been consulted and asked to contribute. A relative confirmed this and told us they continued to feel very involved in their family member's on-going care.

Care plans were evaluated monthly to ensure they remained appropriate and met the person's needs. Care planning had been adapted as people's needs changed, for example, where a person had become frailer, staff had updated their care plan which outlined how they were cared for in bed and needed additional support. Staff reported on people's welfare on a daily basis and handovers were held to make sure significant information was passed on between shifts. Care reviews were carried out at six monthly intervals, giving people and their relatives opportunities to discuss and agree the care provided.

In some people's bedrooms we observed there was 'five things you should know about me', which gave staff information about the individual and what was important to them. We noted the provider had invested in installing 'memory boxes' (for photographs and objects to help stimulate the memories of people living with dementia) outside of bedrooms, though most were empty and this work was still in progress. People had care plans for support in meeting their social needs. Records of the activities each person had participated in were kept in their bedroom, enabling relatives to refer to them.

Most of the people and relatives we talked with were very happy with the level of social stimulation provided at the home. They told us, "There's always something going on and regular entertainment", "I'm impressed with the trips and events the activities team organises. They also let visitors take part" and "I love the therapy dog. All the people love it as many of them had pets of their own when they lived at home." One person explained to us that they had sensory impairments and at times felt quite isolated. We talked to the management team about this and they told us they would pursue further external communication services

to help support the person.

The home employed an activities co-ordinator who arranged a varied, monthly programme of activities, outings and events. This included different games, crosswords, film afternoons, music and sing-a-longs, reminiscence, 'news of the day' and pampering. Aromatherapy and exercise sessions were carried out by people who visited the home. The current programme also included a visiting singer, a Halloween and fireworks night, three outings and religious services. We were told people had taken part in and enjoyed virtual reality reminiscence sessions. These involve wearing goggles to be 'transported' to different areas of interest and further sessions were being organised.

A mini-bus had been purchased earlier this year, with a person living at the home leading the ribbon cutting ceremony. The deputy manager told us the provider ran competitions between their care homes and people at Eighton Lodge had won a 'bake off' event last Christmas. The home also usually entered the annual 'Gateshead In Bloom' competition and had won on previous occasions. Although this had not been held in 2015 and 2016, people had planted flowers and a staff member told us the attractive, well-maintained gardens were well used in warm weather.

None of the people and relatives we talked with had any complaints about the service. One relative said, "I've no complaints at all. I'm more than happy." Another relative said they had no complaints and would feel able to raise any concerns with the registered manager if necessary. They did however comment that they felt the refurbishment work in the home was taking too long to complete.

The provider had a complaints procedure that was given to people and displayed in the home for reference. No complaints had been made in the last year. We informed the registered manager of an anonymous staff concern made to the Care Quality Commission, which they assured us they would follow up. A number of compliments had been received giving thanks and praise about the service.

Requires Improvement

Is the service well-led?

Our findings

The provider had informed the Care Quality Commission (CQC) in May 2016 of the planned refurbishment of the home. They had given assurance that health and safety regulations would be adhered to and full risk assessments carried out. These assurances had not been kept. We found there were no details of the stages of the refurbishment, what they entailed, or any associated risk assessments available in the home. Documents were subsequently sent over from the provider's head office and we were informed the works were expected to be completed by the end of the year.

The registered manager told us the building work leading off the reception area and in the office doorway had been left unfinished for at least the last couple of weeks. They were not aware when the internal contractors were due to return. We were concerned the contractors had been permitted to leave the areas in a potentially hazardous condition and that since this time these conditions had not been perceived as putting people's safety at risk. The registered manager and deputy operations manager acknowledged our concerns though could give no explanation for why the areas had not been made safe.

The deputy operations manager carried out monthly visits to the home to report on the quality of the service. This monitoring was based on CQC standards of quality and safety and any necessary improvements were set out in an action plan for the registered manager's attention. We reviewed the home's quality assurance records and saw a range of internal audits were listed to be completed on either a weekly or monthly basis. Areas covered included checks of housekeeping, the kitchen, health and safety, care records, finances and a manager's weekly audit with observations. The deputy manager had also conducted spot checks during the night to review the care that people were receiving. They told us there had been no issues arising from their most recent checks.

We noted that some audits, including key performance indicators and medicines audits, were not always done at the stated frequency. We also queried the thoroughness of certain audits and follow up action. There was no proper analysis of accidents and incidents to look at identifying any trends or to prevent reoccurrence. The deputy operations manager told us this had already been identified and would be actioned in future. Audits of 'dementia care' and 'dignity in dining' were based on good practice, though were completed in a tick box format and answered 'yes' to all areas, with no supporting evidence or comments recorded. In some instances the outcomes of audits did not concur with what we had found and observed during our inspection. For example, deficits in medicines recording had not been identified and a lack of photographs to the administration records, although highlighted in the most recent audit, had not been addressed. The registered manager told us they did additional checks of the MARs and observed medicines rounds but did not record any evidence of these checks.

We concluded that the systems in place to assess, monitor and improve the quality and safety of the service, and to mitigate risks to people living at the home, had not been effective.

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

The service had a manager who had registered with the Care Quality Commission (CQC) in April 2015. They understood their responsibility to notify CQC of incidents and events which affected the service, though there had been one omission. This was in relation to a time when the passenger lift was out of order and six people had been temporarily relocated.

The provider had displayed the CQC's rating of the service in the home and on their website, as required, following the publication of the last inspection report.

The registered manager told us they received regular contact and support from the deputy operations manager, who was present and assisted during the inspection. They were also supported in their role through meetings with other senior management and their peers, and within the home by the deputy manager and team leaders who led shifts. The registered manager's hours were supernumerary to the staffing levels to enable them to focus on providing leadership to the staff team and fulfil their management responsibilities.

People and their relatives were complimentary about the way the service was managed. They told us, "I feel there's good management of the home and the manager is approachable" and "It is well-managed." Staff were equally positive about the management and the support they received. Their comments included, "There's good morale and we're well-supported", "I can talk to the manager and raise anything I want to say at meetings", "You can talk to the management about any problems and they're very approachable" and "The owners seem to be spending an awful lot of money improving the place."

The last staff meeting, held at the end of August 2016, had been specific to a discussion about the provider's whistleblowing, safeguarding and confidentiality policies. The next meeting was planned to be more structured, with a wider range of topics on the agenda for debate. A survey was also being carried out to get staff's views on a range of factors to measure how well they felt dignity in care was implemented in practice at the home.

News about the provider's company and care services was made available to people and their visitors in a quarterly publication 'The Wellburn Post'. The provider and Eighton Lodge also had pages on a social media website. A box was provided in reception for posting comments and any received were sent directly to head office for review. The home also publicised an independent website where people and their representatives could post their reviews about the service.

Further efforts were being made to improve how the service worked inclusively and obtained feedback from people and their relatives. Surveys undertaken in 2015 had been completed by only two people living at the home and we were told relatives were being included this year to gauge their satisfaction with the service. There had been limited or no attendance at relatives meetings to date. The deputy operations manager said they were aiming to encourage more participation by combining the next meeting with a social event.

The registered manager informed us one the home's cooks had won the provider's star employee of the month award that had been introduced this year. The management team told us about developments in the service which had either been undertaken this year or were in progress. These included the upgrade of the building, the introduction of two days of administrative support for the home, sharing updated policies and procedures with staff and improved training methods. Meetings for managers within the company to share ideas had been organised and meetings for staff with other roles, such as activities co-ordinators, were being arranged to share best practice.

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 The provider had not done all that was reasonably practicable to reduce risks to the safety of people using the service. Regulation 12 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that effective systems were operated to assess, monitor and improve the quality and safety of the services provided and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. Regulation 17 (1)(2)(a)(b)