

Mariposa Care Limited

# Ferndene Care Home

## Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Good 

Is the service well-led?

Inadequate 

# Summary of findings

## Overall summary

This inspection took place on 17 October 2018 and was unannounced. Ferndene is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It provides accommodation for older people and those with mental health conditions or dementia. The home can accommodate up to 48 people in one adapted building. The home is divided into two units one upstairs and another on ground floor level. At the time of our inspection there were 41 people living in the home.

At the time of our inspection there was a registered manager in post. 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.

The service had previously been rated as 'requires improvement' in 2015 and 2017. At this inspection the service was rated as 'requires improvement'. This was the third consecutive time the service was rated as 'requires improvement'. The service had made some improvements but had not fully addressed the issues raised at previous inspections. At this inspection we found breaches of regulation 18 and regulation 17. There was insufficient numbers of suitably skilled staff. Due to the failure of the provider to address issues previously identified at inspection there was a breach of regulation 17.

The provider had ensured that there was usually a sufficient number of staff on duty however some staff did not have the experience required to carry out their duties. People told us that they received person-centred care. Sufficient background checks had been completed before new staff had been appointed according to the provider's policy. A system was in place to carry out suitable quality checks and appropriate checks had been regularly carried out, however action plans were not always in place to address issues identified.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse including financial mistreatment. Most risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. The environment was clean. Staff did not adhere to arrangements to prevent and control infections.

Guidance was in place to ensure people received their medicines when required. Processes were in place to manage medicines. Where people required their medicines via a specialist method to administer food arrangements had not been in place to ensure the method of administration did not affect the efficacy of the medicine. We have made a recommendation about the management of some medicines.

Where people were unable to make decisions, arrangements were in place to ensure decisions were made in people's best interests. Best interests decisions were specific to the decisions which were needed to be made.

Care was not always delivered in line with current best practice guidance. There were ongoing issues with regard to staff not consistently treating people with dignity and respect. Arrangements were in place to ensure staff received training to provide care appropriately and effectively. People were helped to eat and drink enough to maintain a balanced diet. People had access to healthcare services so that they received on-going healthcare support.

People were supported to have choice and control of their lives. Staff supported them in the least restrictive ways possible. The policies and systems in the service supported this practice.

People were usually treated with kindness and compassion and they were given emotional support when needed. They had also been supported to express their views and be involved in making decisions about their care as far as possible. People had access to lay advocates if necessary. Confidential information was kept private.

Information was provided to people in an accessible manner. People had been supported to access a range of activities. People were supported to access local community facilities. The registered manager recognised the importance of promoting equality and diversity. People's concerns and complaints were listened and responded to improve the quality of care. Arrangements were in place to support people at the end of their life.

The registered manager encouraged a positive culture in the home. Staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns. People, their relatives and members of staff had been consulted about making improvements in the service. There were arrangements for working in partnership with other agencies to support the development of joined-up care.

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe.

Where people required their medicines via specialist feeding method arrangements were not in place to ensure the method of administration did not affect the efficacy of the medicine. Medicines were managed safely and medicine records were fully completed.

Effective arrangements were not in place to ensure there were sufficient experienced staff to ensure people were cared for safely.

Arrangements were in place to prevent the spread of infection. However, staff did not follow guidance consistently.

Risks to people's safety had not been consistently assessed, monitored and managed so they were supported to stay safe.

Arrangements were in place to safeguard people against avoidable accidents.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Recruitment checks were fully completed.

**Requires Improvement**



### Is the service effective?

The service was not consistently effective.

The environment was not appropriate to meet people's needs.

Arrangements to ensure where people were unable to consent this was provided by a person who had the legal authority to consent were not consistently in place.

The provider acted in accordance with the Mental Capacity Act 2005. Arrangements were in place to protect people from having their liberty restricted unlawfully.

Staff had received sufficient training and support to assist them to meet the needs of people who used the service.

**Requires Improvement**



People had their nutritional needs met. People had access to a range of healthcare services and professionals.

### Is the service caring?

The service was not consistently caring.

People did not always have their dignity maintained.

Staff usually responded to people in a kind and sensitive manner.

People were supported to make choices about how care was delivered and care was provided according to people's choices.

**Requires Improvement** ●

### Is the service responsive?

The service was responsive.

Care records were personalised. Reviews had been carried out to ensure records were up to date and reflected people's current needs.

People had access to a range of activities and leisure pursuits. People had access to the local community.

The complaints procedure was on display and people knew how to make a complaint.

The provider had arrangements in place to support people at the end of their life.

**Good** ●

### Is the service well-led?

The service was not well led.

Issues identified at previous inspections had not been fully addressed.

Quality assurance processes were not effective in identifying shortfalls in the care people received and improving the quality of care. Actions had not consistently been taken to ensure any identified issues were addressed and the service improved.

Staff were listened to and felt able to raise concerns. There was an open and supportive culture within the home.

The provider had notified the Care Quality Commission of events in line with statutory requirements. A registered manager was in

**Inadequate** ●



# Ferndene 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 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 was a comprehensive inspection.

This inspection took place on 17 October 2018 and was unannounced.

The inspection was carried out by two inspectors, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered nurse.

We examined information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

The provider had completed a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report

During the inspection we spoke with 24 people who lived at the service, nine relatives, 4 members of care staff, two nurses, the area manager and the registered manager. We also looked at six care records in detail and records that related to how the service was managed including staffing, training and quality assurance.

## Is the service safe?

### Our findings

At our previous inspection the service was rated 'Requires Improvement' in 'Safe'. The provider had not put in place arrangements to adequately protect people against the risks associated with the unsafe use and management of medicines. We also identified concerns about the high use of agency staff and people told us they did not think there were sufficient staff to meet their needs. At this inspection we saw arrangements to ensure the safe use of medicines had improved, however there remained issues. We also identified that staffing issues remained a concern. The rating remains 'Requires Improvement'.

One person said, "There's not really enough staff, sometimes you have to take a back seat, say if somebody wanders around a lot and needs attention then you don't get any attention". A relative said "I don't think there's enough staff to be honest, they work hard". Another said, "The staff are very nice, they do look after them, there's not really enough to spend time with people".

The registered manager told us they had put in place arrangements to ensure there was sufficient staff to support people. A dependency tool was used to ensure there were sufficient staff to meet the needs of the people who lived at the home. However, we were told that there were usually seven care staff on shift and that four were upstairs and three downstairs plus two nurses on duty during the day. When we looked at the rota for the week commencing 1 October 2018 we found that on only one occasion these numbers were achieved. At the time of our inspection the home had a total of 126 vacant nursing hours per week. We observed the home was having to use agency nurses on a regular basis to meet their staffing requirements and cover these hours. For example, we saw for the week of 15 October there was at least one agency nurse on duty each day. We spoke with the registered manager who told us they tried to use the same nurses on a regular basis to help with continuity for people but this was not always possible.

On the day of inspection, the agency nurse in the upstairs area was on their first day at the home. Although they received some support from the nurse working in the downstairs area who was employed by the provider they told us they were struggling. We observed when we asked the whereabouts of a person they had to refer to their handover sheets to check the room number and details. The sheets had space for the inclusion of photographs so staff could easily identify people, however we observed not everyone had a photograph in place. There was a risk staff who were unfamiliar with the home would not recognise people who required support. There was a risk that people would not receive appropriate care because of the lack of consistency of staff.

When we checked the records of fridge temperatures we saw there were several days when the temperature had not been recorded. We spoke with a member of staff about this who said this was when agency staff were in charge as it tended to be overlooked. This meant there was a risk medicines would be stored at the wrong temperature and their effectiveness affected.

"A relative told us, "They appear to have a difficulty with getting and keeping staff, there's a lot of Agency (staff), mainly on the nursing side. The Agency Nurses are very good, some of them introduce themselves and that helps". Another said, "The main concern is the use of agency staff, they are trying and are getting



there but it is still a problem."

One relative we spoke to told us they felt there was a difference between the levels of care on the two floors. They said, "It seems the quality of care is better downstairs. That seems to be the centre of where things go on. There doesn't seem to be any staff around up here. I've had to spend 20 minutes once trying to find a member of staff when someone's (call) light was flashing. Yesterday [family member] didn't have their dinner. When I came in at 2pm they were in bed, fully clothed with their drink and sandwiches by the bed untouched."

During our inspection we observed during lunchtime people in the upstairs unit were waiting for support with their meals. For example, a person in the upstairs lounge was still waiting for assistance with their meal at 1.30 pm and had been sat in the dining area since 12.52pm.

This was a breach of Regulation 18. There were insufficient suitably skilled and knowledgeable staff available to meet people's needs.

Two people received their medicines via a specialist feeding tube, Percutaneous endoscopic gastrostomy (PEG). Most medicines are not licensed for administration via enteral feeding tubes. National guidance (BAPEN) states that staff should seek advice on how medicines should be administered via PEG tubes. The registered manager told us that they sought advice on this in March 2018 but had not received a response. An external audit carried out in March 2018 also identified this issue. We were not assured that people were receiving their medicines via the PEG tube correctly. Following our inspection, the registered manager confirmed they had again contacted the pharmacist for this advice. People were at risk of their medicines not being effective due to the method of administration.

Recommendation: The provider should ensure that staff always have appropriate advice on how medicines should be administered via Percutaneous endoscopic gastrostomy tubes, and ensure that this is recorded.

Another person had their tablets later than prescribed because they liked to have a lie in. However, it was not clear on the medicine records when medicines were given to ensure the medicine were administered with the appropriate gap between. We spoke with the registered manager about this who told us they would address this.

We observed people were supported to take their medicines in the method they preferred, for example, with juice or water, and this was recorded in the medicine records. Each medicine record had a front sheet and allergies were consistently recorded on these. Information to support staff when administering as required, (PRN) medicines, was available to staff to ensure people received their medicines when they needed them. We found that suitable arrangements were in place to safely manage people's medicines in line with national guidelines.

People told us they felt the home was clean. One person told us, "My room is always nice and clean, looked after well". Another said "Cleanliness is well taken care of. My room is clean and the bathrooms".

We observed suitable measures were in place for managing hospital acquired infections. However, we observed two members of staff who were serving food not taking the recommended precautions to avoid the spread of infection. For example, one member of staff who was handling sandwiches coughed into their hands and wiped their nose. They continued handling the food without washing their hands. Another member of staff wiped their hands on their apron in between serving food items with their hands and did not wash between. The Food Standards Agency Guidelines detail the importance of hand washing in such

situations to avoid cross contamination.

We found that most risks to people's safety had been assessed, monitored and managed so that people were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents and where people had specific health issues. However, we observed people sat in slings for the period of our inspection. The Prevention and Management of Pressure Sores (2009) states that, 'slings should not be left under the person' and 'where there are associated manual handling issues concerning the removal of a hoist sling, a joint assessment by tissue viability and manual handling staff should be documented'. We spoke with the registered manager about this who told us the slings were specifically designed for remaining in situ, however they were unable to provide evidence of this and care plans and risk assessments in relation to this were not in place. People were at risk of pressure damage because of sitting on slings for long periods of time and risk assessments not in place.

People told us that they felt safe living in the service. However, two people and two relatives expressed concern about people entering the bedrooms of people who lived at the home. One relative told us, "There is one person who tours around and comes into [family member] room but they are no risk and if staff see them they take them away straight away". Another said, "There was a problem with a person coming in the room in a wheelchair. But staff are attentive, I don't feel worried." We observed some people had gates at their bedroom doors to prevent this happening.

One person told us, "There's a buzzer in my room at night. I can't always get to it, it might be on the floor and I have to lean out. It depends on how busy they are. It does take time sometimes half an hour, sometimes longer, they could do with more staff. It's not a lack of will to get to you, it's that they will have somebody needing them more, they are stretched." There was a risk the person would not be able to summon support when required.

Arrangements were in place to protect people in the event of situations such as fire or flood. For example, personalised plans to instruct staff how to support people in the event of an emergency were in place. We found that the registered persons had ensured that lessons were learned and improvements made when things had gone wrong. Staff told us they received feedback on incidents and accidents. Records showed that arrangements were in place to analyse accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed that care staff had completed training and had received guidance in how to protect people from abuse. We found staff knew how to recognise and report abuse so that they could act if they were concerned that a person was at risk. Staff told us they thought people were treated with kindness and they had not seen anyone being placed at risk of harm. We also noted that the provider had established transparent systems to assist those people who wanted help to manage their personal spending money to protect people from the risk of financial mistreatment.

Staff were supported to promote positive outcomes for people if they became distressed. For example, guidance was available in people's care plans so that they supported them in the least restrictive way. When we spoke with staff they could tell us about these. Relatives told us that staff dealt well with people who were confused or distressed.

We found that in relation to the employment of new staff the registered persons had undertaken the necessary checks. These measures had helped to establish the previous good conduct of the applicants and

to ensure that they were suitable people to be employed in the service. The registered persons had carried out checks with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct.

## Is the service effective?

### Our findings

At the previous inspection this domain was rated 'Requires improvement' because we found staff had not received regular supervision and the provider had not acted in accordance with the Mental Capacity Act (MCA)2005.

At this inspection we found arrangements to provide supervision and support to staff had improved. Staff had not received supervision on a regular basis but arrangements were in place to address this. Yearly appraisals had been carried out with staff. This is important to ensure staff have the appropriate skills and support to deliver care effectively. The provider had acted in accordance with the MCA, however there remained issues relating to consent. We also identified other issues and the domain remained, 'Requires Improvement'.

Where people were able to consent, documentation was included in the care records. However, in three of the records we reviewed in detail only one person's information regarding consent to share records and have photos taken had been signed. The record had been signed by a family member who it was later ascertained did not have legal authority to consent on the person's behalf. There was evidence in the records that the registered manager had recently undertaken to verify who had legal authority to consent on people's behalf however this was not consistently reflected in the consent documentation. We spoke with the registered manager who told us they were in the process of reviewing this documentation.

The home was purpose built home with wide corridors and plenty of natural light. However, there were few adaptations to assist those people who were confused or had difficulty with orientation around the home. All the doors were the same colour with limited differentiation between people's bedroom doors and the doors to toilets, bathrooms and store-rooms. We saw that people's bedroom doors had small numbers on them and there was no use made of name plates, photos or memory boxes to enable people to identify their room more easily. Where people required specific equipment to assist them with their care this was in place and appropriate checks made regularly to ensure it was safe.

We observed that the carpet on the stairs and landing at the rear of the home was threadbare causing a trip hazard for staff and any people who used that stairwell. The registered manager explained that this had been reported but agreement had not been given to purchase a replacement.

Introductory training was in place in line with the National Care Certificate for new staff. The National Care Certificate sets out common induction standards for social care staff. People were confident the staff knew what they were doing and had their best interests at heart. Members of staff told us and records confirmed that they had received introductory training before they provided people with care.

Staff had received refresher training to keep their knowledge and skills up to date. When we spoke with staff we found that they knew how to care for people in the right way. Where people had specific needs, we observed training was provided. For example, a nurse we spoke with told us they were going on training about specialist feeding regimes (PEG) feeding. Staff told us they felt supported and could speak with the

registered manager if they needed to.

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 law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Staff supported people to make decisions for themselves whenever possible. Records showed that when people lacked mental capacity the registered manager had put in place a decision in people's best interests. These were decision specific as required by national guidance.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection people were subject to DoLS and appropriate arrangements were in place.

Care records indicated where people had capacity to consent to their care and treatment or if another person had legal authority to give consent that this had been given. Do not attempt cardiac pulmonary resuscitation orders (DNACPR) were in place where appropriate and had been reviewed.

We observed lunchtime. People were supported to eat and drink enough to maintain a balanced diet and where required adapted equipment was available if people needed them to assist them with eating. We observed drinks were provided throughout the day in communal and bedroom areas. Where people had specific dietary requirements, we saw these were detailed in care records and staff were aware of these. Risk assessments and plans to minimise the risk were in place where people were at risk of not receiving adequate nutrition because of their physical health.

One person told us, "The kitchen staff are brilliant. "I've put on weight while I've been here. They are very obliging, if there's anything you want they'll try and do it for you, here is a menu, they come during the day and ask you what you want from that. There's a choice of four things for lunch and two for tea". We observed a member of staff ask a person in the morning what they wanted for lunch and tea. We saw that they explained the choice in a kind and patient manner. A visiting relative said "The food is very good. I come to help with feeding but that is what I want to do. [Family member] has to have a special diet and they do that very well".

Records confirmed that people had received all the help they needed to see their doctor and other healthcare professionals such as specialist nurses, dentists, opticians and dieticians. Reviews were held with people and professionals who were involved in their care. Where people had specific health needs for example diabetes, care plans reflected this and detailed how to meet these needs.

A relative told us, "The doctor comes in regularly to see [family member]. If we need him at other times we just ask them [staff] and they get him. They certainly look after [family member], they got a doctor straight away when they saw [family member] had an eye infection, they got tablets the next day." Another relative told us, "Two weeks ago [family member] was rushed to hospital when one of the nurses noticed a problem with their mouth, they acted straight away."

## Is the service caring?

### Our findings

At the previous inspection this domain was rated 'Requires improvement' because we found that people did not have their dignity consistently considered. At this inspection the domain remained 'Requires Improvement'.

We found people's dignity was still not consistently respected. For example, we observed in the upstairs dining area staff putting aprons on people without asking if they wanted to wear an apron. We also observed staff talking amongst themselves and not interacting with people during lunchtime. In addition, two staff members laughed at a question a person posed rather than trying to explain to the person their mistake. On another occasion we observed a member of staff speaking to a person in an abrupt manner telling them to be quiet. We reported this to the registered manager who took appropriate action.

In the upstairs area we observed at 12.35 pm a person had knocked a glass of drink and a container of food supplement off their bedside table and onto the floor. This had spread over a significant area of the floor carpet and this, the container and the spoon could be clearly seen from the corridor through the open room door. The person was in their bed at the time. We observed three members of staff walk past the room but not address the issue. We observed a fourth member of staff enter the room at 12.41pm and clean up the spillage. During lunchtime we observed few positive interactions from staff and saw staff supported people without explaining what they were doing or speaking to them.

We observed staff knocked on people's bedroom doors and called them by their preferred name. People told us staff were respectful when supporting them with personal care and they had never felt undignified or embarrassed. A person said, "On the whole they do treat us with respect, knock before coming in, don't talk down to you. When they help me out of bed we have a laugh but they make sure the door is closed and the curtains shut". We found that suitable arrangements had been maintained to ensure that private information was kept confidential. Computer records were password protected so that they could only be accessed by authorised members of staff.

People told us staff were caring and kind. One person said, "The carers are brilliant, they really care, it's like we are family. If you want any shopping doing they'll do it for you, say if you say you have someone's birthday coming up". Another said, "For the most part they are very kind, they treat me like their own grandparent". The registered manager told us their ethos for the home was that it was people's home. We observed a member of staff needed to wake a person to provide care. They approached the person gently and allowed them to wake and be aware of their surroundings before providing the care.

Where people required specific support to prevent them from becoming distressed this was detailed in their care records and guidance was in place to support staff. When we spoke with staff they explained how they reassured people and tried to distract them from the issue that was making them upset. We observed staff using terms of endearment and the residents' preferred name. The staff were calm with people even when they were upset. We saw staff assist a person to have a drink. They explained liked their care to be delivered in a very specific way otherwise they may become upset. For example, the person liked to count when

having personal care and we observed staff supported them to count and counted with them as reassurance.

We found that people had been supported to express their views and be involved in making decisions about their care and treatment as far as possible. For example, a care record stated about a person, "I like to be clean shaven" and explained a person preferred to sleep in a T shirt. Where people were unable to communicate verbally arrangements had been put in place to support them. One care record stated, 'staff to observe for non verbal signs of discomfort such as agitation and facial grimaces'.

We observed staff support a person to move into the dining room. We saw they did this at the person's pace and allowed them to do as much for themselves as they could whilst remaining attentive and staying close. Staff explained what they were doing and how people could assist them when moving.

Most people had family, friends or representatives who could support them to express their preferences. Furthermore, we noted that the provider had access to local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

## Is the service responsive?

### Our findings

At the previous inspection this domain was rated 'Good'. At this inspection we found the service remained 'Good'.

People's views on and experience of the activities provided in the home were positive. One person told us, "We have dominoes downstairs where there is room but they include all residents, up and down, we do crafts and children come in and play bowls and sing and dance. We make things for Halloween and Christmas and go out if we can but we have a problem with so many wheelchairs. Relatives are always invited to any entertainment and they come in and help, say with handicrafts. The kids come in here and they invite us to things at school, Harvest Festival, Christmas lunches. We play board games and do baking. They come and sing and dance and generally enjoy themselves."

We saw a board in the foyer displaying the activities planned for the week. The board had large, bright images and large, clear text. Activities included, arts and crafts, quizzes, picture quizzes, pampering, exercises and games. During our inspection we observed a game of skittles being organised in the afternoon. The home also used outside entertainers and had a regular organist who came each Friday. Visits from Petting Pets, Exotic Animal Zoos and Clothes Party Planners were also organised.

Links with the local community had also been established. For example, a church choir visited and a local representative from the local Anglican Church attended to give communion once a month. Pupils from a nearby school visited to work in the garden and the home had, through one of the people who lived at the home established close connections with the local primary school. Children from this school visited regularly to sing and play games and residents from the home were invited to school events such as the Harvest Festival and Christmas lunch.

People said that nurses and care staff provided them with all the assistance they needed. We found that people received care that was responsive. For example, a husband and wife both lived at the home and attention had been paid to their routines and accommodation, being developed as an apartment. However, little of this was reflected in the care planning records. We spoke with the registered manager about this who said they would address the issue.

Care records did not consistently include assessments carried out before people came to live at the service. Records showed that staff had subsequently consulted with each person about the care they wanted to receive and had recorded the results in an individual care plan.

People told us that staff encouraged them to be independent and do as much as they could for themselves. One person said, "They encourage me to walk using my frame". Another said, "I try and do what I can for myself and they let me do that but they always say if there's something you can't tackle give us a buzz." Care plans were regularly reviewed and reflected people's changing needs and wishes. People told us they had been involved in developing their care plan. A daily handover sheet was provided which detailed significant issues about people's care needs for example, if they required a specialist diet and any short-term needs



such as infections or recent falls.

Care plans and other documents were written in a user-friendly way in accordance with the Accessible Information Standard so that information was presented to people in an accessible manner. We saw people had been involved in discussions about their care plans. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Relatives told us they felt welcomed at the home and we observed staff speaking with relatives and chatting with them. We noted that staff understood the importance of promoting equality and diversity and people were treated as individuals. For example, people we spoke to told us that they had been given a choice in regard to female or male carers. Furthermore, the provider recognised the importance of appropriately supporting people if they identified as gay, lesbian, bisexual and transgender. One person told us, "My family and friends can come in any time. All my friends have pointed out how welcome they have been made when they come here."

There were arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. When we spoke with people they told us they knew how to raise concerns. One relative told us how the registered manager's response to their concerns over her family member's care had impacted positively on them. They told us, "The registered manager has made a lot of difference. She's approachable and so supportive. [Family member] wasn't very happy upstairs and it wasn't very clean. When the new manager came I asked if [family member] could have a room downstairs and the registered manager got a room painted. Our [family member] is really happy and I can leave now and know they are alright. I don't worry now. I know [Family member] is loved and looked after. If there's a problem they get hold of me."

The provider had arrangements in place to support people at the end of their life. For example, where people chose to, care plans included information of what they wanted to happen in the event of illness and subsequent death. The provider had put additional training in place to ensure staff felt confident in supporting people at the end of their life.

# Is the service well-led?

## Our findings

We have carried out three comprehensive inspections at this service. On all three occasions, the service has been rated as 'requires improvement', with repeated issues highlighted as concerns and any improvements not always being sustained. The service has not fully met some of the regulations since 2013. We have taken this into account when considering our rating in this domain.

In September 2017 we had identified concerns about the high use of agency staff and people told us they did not think there were sufficient staff to meet their needs. At this inspection we found effective arrangements were still not in place to ensure there were sufficient experienced staff to ensure people were cared for safely. This was a breach of Regulation 18. There were insufficient suitably skilled and knowledgeable staff available to meet people's needs.

We found at this inspection the provider had failed to fully address issues previously identified at inspection. At the previous comprehensive inspection in 2017 we found audits that had been completed did not effectively identify areas for improvement. We found that the registered manager had made several arrangements that were designed to enable the service to develop. For example, following our previous inspection an action plan had been put in place and issues addressed. Regular checks were in place for a variety of issues however action plans were not always in place to ensure the service was developed. Where actions had been identified as necessary we observed they were not always addressed. For example, a medicine audit identified the need for specific advice in March 2018 and this had not yet been received. Arrangements for checking the quality of the service were not consistently effective.

The previous inspection had also identified people were not treated with respect and dignity. At this inspection we continued to find incidences where people were not treated with dignity and respect.

The provider did not have arrangements in place to ensure national guidance was followed. At this inspection we found that where people required their medicines via a specialist feeding method arrangements were not in place to ensure the method of administration did not affect the efficacy of the medicine. We also found concerns about the use of slings and not meeting national guidelines and carrying out risk assessments in relation to the use of slings.

We recommend that the service consider appropriate current guidance and take action to update their practice accordingly.

In addition, we found some gaps in the infection control processes which increased the risks to people. We also found that risks to people were inconsistently managed, which increased the possibility of people being hurt while receiving care.

All these issues showed that the systems in place to monitor the quality of care people received and to drive improvements were not adequate. The service lacks the systems to provide sustainable improvement.

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

At the previous inspection because there was not a registered manager in post at this inspection we found that the registered persons had recruited to the registered manager post.

We found that people who lived in the service, their relatives and members of staff had been engaged in the running of the service. For example, one person told us, "They have residents meetings and family and friends can come they are not as often as they probably could be, the last one has been cancelled twice. We can put our point of view." Two people who lived at the home were involved in organising the meetings and ensuring that people were aware of discussions and issues if they were unable to attend. They were also involved in developing surveys to ascertain people's views. A relative said, "They do have them but usually in the afternoons and I couldn't get to them. They do put it up that they are having them." The registered manager told us they were looking at changing the times of the meetings quality surveys had been carried out with people who lived at the home, their relatives and staff. We saw that responses were positive.

Staff told us they thought there was an open culture. Regular staff meetings were held and staff received feedback from the manager about issues in the home. We looked at minutes from the meeting and saw that issues such as staffing were discussed. Staff told us they were confident that any concerns they raised with the registered manager would be taken seriously so that action could quickly be taken to keep people safe.

One visiting relative said "The manager goes around and talks to people, everybody is treated with respect. She's got the carers working as a team, the food seems better. The home is spotless now, it wasn't always." Another said, "The manager is first class. She delegates and lets staff get on with it but she's no fear of stepping in if needs be. I can knock on her door any time." Staff told us they felt there was a good team environment and staff understood their roles within the organisation. A member of staff told us the registered manager was approachable and organised. They told us they thought there was significant improvement since our last inspection. During our inspection we observed the registered manager around the building, speaking with staff and people who lived at the home.

The registered manager had developed working relationships with local services such as the local authority and GP services. We observed staff had worked with partner agencies to resolve issues. For example, a record of a recent monitoring visit by the local authority detailed where improvements had been made.

Staff told us they thought the registered manager, was approachable and listened to them. They described the home as homely and caring. Arrangements were in place to recognise staff and their contribution to the home. For example, one member of staff said that they had received a 'going the extra mile' award. We looked at the Statement of Purpose which is a document providers are required to have in place detailing the details of the service. We found it reflected current arrangements for management and appropriate reporting of complaints. Records showed that the registered persons had correctly told us about significant events that had occurred in the service, such as accidents, incidents and injuries. The provider had displayed the rating of their previous inspection according to CQC guidelines.

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 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	There were insufficient suitably skilled and knowledgeable staff.