

Barchester Healthcare Homes Limited

The Mount & Severn View

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?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 19 and 23 July 2018 and was unannounced.

The Mount & Severn View is registered to provide accommodation with nursing and personal care to a maximum of 58 people, some of whom are living with dementia. There were 49 people living at the home on the day of our inspection. People's bedrooms are over two floors and the first floor is accessed by stairs or a passenger lift. People have access to communal areas within the home and access to the home's gardens.

A registered manager was not in post at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on 24 August 2017 we rated the service as requires improvement and we found one breach of regulation of the Health and Social Care Act 2008. We asked the provider to take action to make improvements to ensure there were sufficient numbers of staff, people received the care and support they needed and were treated with respect and consideration at all times. We also asked the provider to make improvements to their arrangements to ensure people were protected from abuse and not restrained unlawfully. We asked the provider to send us an action plan. At this inspection we found that some improvements had been made, however further improvements were required.

The systems the provider had in place to identify areas that required improvement and to drive those improvements were ineffective in ensuring the experiences of people had improved since the last inspection.

Staffing numbers had been increased, however people still did not receive care in a timely manner.

Risks to people were assessed and minimised however environmental risks had not been considered.

People were not always treated with dignity and respect and their needs were not always responded to in a timely manner.

Complaints were investigated however there was no system in place to address informal grumbles.

Infection control measures were in place however they had not prevented malodours in some areas.

People were safeguarded from the risk of abuse and their medicines were stored and administered safely.

The principles of the Mental Capacity Act 2005 were followed to ensure people who lacked capacity consented to their care and support at the service.

People were cared for by staff who were trained and supported to fulfil their roles.

People's needs were assessed and they had access to health care agencies when they became unwell or their needs changed.

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.

Although staffing numbers had increased people still had to wait for their care needs to be met.

Individual risks had been assessed however risks within the environment had not been considered.

People's medicines were stored and administered safely.

People were safeguarded from abuse and staff were employed through safe recruitment procedures.

Accidents were investigated and lessons learned when things went wrong.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Some areas of the environment required maintenance to ensure it was safe for its intended purpose.

The principles of the Mental Capacity Act 2005 were followed.

People were cared for by staff who were trained and supported to fulfil their roles.

People's needs were assessed and they had access to health care agencies when they became unwell or their needs changed.

People were supported to eat and drink sufficient amounts to remain healthy.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

People were not always treated with dignity and respect.

People's right to privacy was upheld.

People were involved in decisions about their care.

Is the service responsive?

The service was not consistently responsive.

People's needs were not always responded to in a timely manner.

Formal complaints were responded to however people's informal issues were often left unresolved.

People were offered activities within the communal areas.

People's end of life wishes were gathered and responded to at the required times.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

The provider's system to ensure the quality of care improved for people had been ineffective.

Staff worked in partnership with other health and social care colleagues.

There was a manager in post who was yet to register with us.

Staff told us that they received support and guidance from the manager.

Requires Improvement ●

The Mount & Severn View

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 19 and 23 July 2018 and was unannounced.

The inspection team consisted of three inspectors, one specialist advisor for nursing care and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This inspection was prompted by a number of complaints and concerns we received about the quality of care at The Mount & Severn View. We planned our inspection around the themes raised in these complaints, but did not investigate these, as we do not have the authority to investigate individual complaints. These themes included concerns around staffing levels, the length of time people waited for support, the quality of care delivered and the cleanliness of the home. We had passed complaints we received to the provider and shared the information with the local authority. At the time of our inspection the provider was still looking into one concern under their complaints procedure.

Before our inspection we reviewed other information, we held about the service. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We contacted representatives from the local authority and Healthwatch for their views about the home. We used all of this information to help us plan our inspection.

During the inspection we spoke with twelve people who lived at the home and six relatives. We spoke with fourteen staff which included care assistants, senior care assistants, activity co-ordinators, various ancillary staff, administrators, nursing staff and management. We viewed care records for seven people, including medicine records. We looked at five staff recruitment records and records relating to how the service was managed.

We observed people's care and support in the communal areas of the home and how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

At our previous inspection on the 24th August 2017 we found the service was not consistently safe and had rated the safety of the service as Requires Improvement. At this inspection, some improvements had been made, however further improvements were required

At our previous inspection the provider did not have sufficient staff to support people's needs and people told us they had to wait for their care. At this inspection we found there were now sufficient staff on duty, however people did not always get their needs met in timely way. People and relatives did tell us there were still occasions when they were kept waiting for their call bells to be answered when they needed support. One person said, "Staff are working their socks off. They can't leave someone to come to me. When they can get to you, they will, but when I'm on my bed and I can't move it's awful." The manager reported staffing levels had increased, which was supported by our observations of the rota, as well as comments from staff. However, there was still a concern that some people are waiting longer than appropriate, for aspects of their care to be delivered. Throughout the inspection, staff response times to call bells were monitored. In many instances the bells were answered promptly however we observed occasions where people had to wait. One person told us "You are lucky if anyone answers the bell quickly. You can wait an hour if you need to use the toilet. It is not a surprise if you wet yourself and then you get told off".

The manager told us they completed a weekly dependency tool, kept it updated to reflect any changes in numbers of people or their needs. This is a tool used to identify how many staff are required to support people's needs. The manager said, "It gives a rough estimate but we need to keep reviewing people's needs." They also told us they looked at the skill mix of staff to ensure there was a balance of senior staff, junior staff and new staff, with further plans to improve the allocation of staff teams. The manager told us staff recruitment to the home was underway and they hoped to be fully staffed within four weeks of our visit.

People told us they felt safe living at the home and with the staff who supported them. However, for people who were cared for in their rooms they told us they did not always feel safe because they did not see staff often. Some people also expressed concern because they did not always know the staff that supported them, especially at night. The manager confirmed night time was when most agency staff were used.

Risks to people's safety were not always considered by staff. We saw a basket of gloves and aprons had been left in a corridor. A staff member, who was pushing a person in a wheelchair, had to move this basket out of the way so they could get past. Corridors or escape routes should not be blocked. Another person had their bed against a radiator, with no barrier in between. Although the radiator was not on at the time it did have sharp edges which could cause injury to the person. We spoke with the manager about this and the bed rails were raised on that side of the bed. The manager also confirmed they had arranged for a radiator cover to be fitted.

We had received concerns around the maintenance of equipment within the home, including wheelchairs. Where people required equipment to help them stay safe or move around the home, this was maintained

and serviced as required. The maintenance assistant told us they were going to increase the frequency of wheelchair checks to weekly to ensure all were looked at and cleaned regularly. We saw there were personal emergency evacuation plans in place for each person living at the home. These detailed the support people would need to evacuate from the home in the event of a fire or any other emergency. This helped people to stay safe within their environment.

The provider's recruitment policy and procedures helped to minimise risks to people's safety. Before prospective staff started work at The Mount and Severn View, they were subject to identity and past employment checks. The provider also completed checks with the Disclosure and Barring Service ("DBS"). DBS checks are used to vet staff and prevent unsuitable people from working in care. Registration details for nursing staff were checked with the Nursing and Midwifery Council to ensure these were valid and current. This helped to ensure potential new staff were suitable to work with people living at the home.

People were supported by staff who understood how to protect them from potential harm and abuse. Staff understood how to report concerns both within and outside of the home. Our records show that where an allegation of abuse or concerns about people's safety had been reported the provider took the appropriate action, followed local authority safeguarding procedures and notified CQC as required. This meant that people were safeguarded from potential abuse.

We saw documented plans were in place to manage identified risks and keep people as safe as possible. These plans took into consideration key areas of risk, such as people's long-term health conditions, their mobility, nutrition and any specialist care equipment they used. Staff followed healthcare professional's advice such as, following physiotherapy advice where people had reduced mobility or the monitoring of people's skin condition. Staff were aware of risks associated with people's care and knew the support they needed to help keep them safe.

People were supported by the nursing staff to take their medicines when they needed them. We saw nurses checked each person's medicines with their individual records before administering them. This made sure people got the right medicines. The nurse asked people if they wanted their medicines and we saw they assisted people to take their medicine in the way they preferred. People were not rushed and the nurses stayed with people whilst they took their medicines. When not attended, the medicine trolley was kept locked and secure to help prevent people accessing medicines that were not theirs. Some people had medicine given to them only when they needed it, such as pain relief. Information in people's records gave staff clear instruction on why and when people might need these medicines. Records were also kept to record when people had requested PRN medicine and how effective it had been. This helped to monitor the effectiveness of the medicine in meeting people's needs. We saw medicines were stored securely and medicines trolleys were left secure when not in use. Temperatures were monitored in the areas where medicines were stored, including fridges to ensure they were kept at the optimum temperature. The provider had systems in place to ensure information relating to people's medicines was recorded appropriately, including topical medicines. This helped to ensure people were protected by safe systems for the storage, administration and recording of medicines.

The provider had systems in place to prevent the risk of infection. However, these systems had not been effective in managing malodours in one area of the home. At our last inspection we had noted a strong smell of stale urine from bedroom carpets in one area of the home. We were told at the time by the provider these would be replaced with vinyl flooring which would be easier to keep clean. We had also received concerns about the cleanliness of the home. At this inspection we found the flooring had not been replaced and the malodour was still present. The manager confirmed this had been requested and was due to be completed the day after our inspection visit. Since our inspection we have had confirmation this has been completed.

Staff understood their responsibilities in relation to infection control and hygiene. We saw staff used protective equipment such as gloves and aprons and there were handwashing facilities throughout the home.

Staff understood their responsibilities to report safety incidents, concerns and near misses. They knew they could escalate their concerns to the local authority or to us if they felt appropriate actions had not been taken by the provider. We looked at records of accidents and incidents that had occurred at the service and could see people's care plans were updated to reflect any changes in people's care. Safety concerns were reviewed and investigated by the manager. After starting work at the home, the manager had identified a higher than average amount of people experiencing skin tears. They had investigated the causes of this and arranged for the provider's manual handling trainer to observe staff practice and established staff were not using correct equipment. New processes and increased training had been put into place and the manager told us they had started to see a decrease in this type of incident. This demonstrated the registered manager analysed incidents and took action to ensure people were safe from harm.

Is the service effective?

Our findings

At our previous inspection on 24th August 2017 we found the service was not consistently effective and had rated the effectiveness of the service as Requires Improvement. At this inspection we found improvements had been made however further improvements were required.

Although not purpose built as a care home, the premises had been adapted to meet people's needs. We saw the home was in need of redecoration, especially on the first floor where there were noisy and uneven flooring in places. Staff had difficulty moving equipment around some parts of the home because corridors were narrow. Some people's rooms were cluttered with furniture and equipment which made it difficult for staff to use equipment such as hoists. There was also a lack of storage for equipment and records throughout the home. The regional director and manager told us the provider had planned for a major refurbishment of the home and although a date had not yet been agreed, they anticipated this would commence later in this year. The refurbishment would help to address the lack of storage and improve the flooring, along with redecoration of the home.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection we had found that records were not clear in showing how decisions had been made for people who lacked the mental capacity and generic pre-printed forms were used. At this inspection we saw improved records in relation to decision making and who had been involved in making decisions on people's behalf. We saw capacity assessments were in place to establish whether people had capacity to make their own decisions and were mostly specific about the decisions to be made. Staff had assessed the restrictions placed upon each person and made Deprivation of Liberty Safeguards (DoLS) applications for people who lived in the home, where required. This was mostly because they were not able to make decisions in relation to keeping themselves safe. This helped to ensure people's rights were protected and their best interests considered when decisions were made on their behalf.

During our visit we observed people were asked to give their consent to care and treatment by staff. Staff had received training in the MCA and understood its role in keeping people safe when they could not make their own decisions. Staff told us they always gave people the opportunity to make their own choices and consent to their own care.

People's needs were assessed prior to moving into the home and being supported by staff. One person who

had recently moved into the home told us the manager had come to assess them. They said the manager had spent time with them to find out their needs and they had not felt rushed. Since moving to the home, they told us they were being well looked after, staff were all friendly and they felt staff just needed to get to know their preferences, which they knew would happen over time.

We saw people's care plans were comprehensive, with advice from health care professionals utilised to help ensure care plans adhered to best practice guidance. Plans were in place for areas such as pressure area care which were kept up to date to show the action taken and improvements made. People's ability to communicate and any hearing or sight deficits were also assessed and plans in place to show how staff were to support them. Where risk had been identified, care plans gave staff the information they needed to meet people's needs such as with eating and drinking, their mobility or specific health conditions. This showed people's needs were assessed and care was effectively planned to meet those needs.

We saw equality, diversity and human rights (EDHR) was discussed with people to find out if they had, for example, any specific cultural, religious or social needs. Although it had been identified where people had specific social, cultural or religious needs, the care records did not always provide staff with information about how to meet these needs, for example for people who had said their religion was important to them. However, staff demonstrated they knew people well and treated them equally with regards to EDHR.

People were referred to and supported to access healthcare services as required to help maintain their health and well-being. Health visits and their outcomes from people's GP, community nursing teams, hospital appointments and other health appointments were recorded. People's skin integrity was monitored and treatment delivered where needed. Effective recording of wound care was completed to highlight the process of and the efficacy of treatments used, which was good practice. This information helped staff to review the effectiveness of people's care plans and ensure effective care was planned to meet those needs.

People received care from staff that were effective in their roles. Staff received a range of training and support relevant to their role. They had access to training, which gave them the skills and knowledge to support people's individual and specific needs. One staff member told us, "We get plenty of training, we are supported to be up to date on main courses and can choose extra ones if we want." All staff agreed they had the support they needed and nurses told us they were supported to maintain their professional registration and competence.

Staff told us they received a handover at the start of each shift. This gave them information they needed about changes to people's needs or conditions. It included details about who needed assistance to change position frequently and who needed encouragement to eat and drink. One care staff told us, "The nurses are brilliant. They support us and help us to give good care."

People were supported to have enough to eat and drink and maintain a healthy diet. People told us they had enough to eat and were offered drinks and snacks throughout the day. Risks associated with people's ability to eat and drink or special diets they needed had been assessed and were followed by staff. Staff knew who was at risk of choking, needed thickened fluids or their meals pureed. Staff supported people with diabetes in making healthy choices, for example, choosing foods low in sugar. We saw staff completed monitoring of people's food and fluid intake where needed. One staff member told us running totals were kept of what people drank. The nursing staff and the manager kept these under review and if people were not drinking enough throughout the day staff were informed to encourage people to drink more. This helped to ensure people were kept hydrated and received sufficient nutrition.

Is the service caring?

Our findings

At our previous inspection on 24th August 2017 we found the service was not consistently caring and had rated this key question as Requires Improvement. At this inspection we still had concerns in how people were treated.

At our last inspection people had to wait too long for support and their dignity was often compromised because of this. At this inspection most people told us they did not often have to wait for too long. However, some people told us they still were kept waiting and this had an impact on them. One person told us they had, in the past, used their own telephone to call the home's office when staff did not respond to their call bell. However, they went on to tell us this had improved recently.

We found people had differing experiences about the care they felt they received. While some people were positive about the care they received, others were not. Most people told us staff were caring towards them. One person said the staff were "very friendly people". People and relatives told us consistency and timeliness of care had improved since the new manager had arrived, although they did feel there were still improvements to be made. One relative said, "There are a lot of people here who need a lot of help and it is very time consuming for staff. I hope it will continue to get better as it could be a really nice place to be."

We saw a mix of positive and neutral interactions from staff towards people, with a significant amount of interactions being task focused. We saw one person sat alone in one of the first-floor dining rooms whilst staff walked past but did not interact or engage with them. This person eventually fell asleep. On our second day we noted this person was sat, asleep in their nightclothes at the dining table with their breakfast dishes in front of them. The area the person was sat was a 'thorough fare' where staff walked through regularly. We saw this in other areas of the home where dining and seating areas were thorough fares for staff and there was often a lack of interaction or acknowledgement from staff to the people who were sat there. We saw one person ask a care staff where their tablets were as they had not received them yet. The care staff told the person they would speak with the nurse and find out for them. The care staff did not return.

People's dignity was not always respected or promoted by staff. We saw one person being pushed through the communal area of the home in a shower chair. This person's dignity was compromised as part of their body was not covered. The manager spoke with the staff member and found out this had been standard practice for this person, who had agreed to this. They confirmed this unsafe and undignified practice had now been stopped. However, we did see some positive, compassionate and respectful interactions. We saw a staff member support a person with their meal at the dining table. This was done in a way which maintained the person's dignity, with the staff member asking the person's preference about the support they wanted.

People and relatives we spoke with were satisfied with the support and opportunities they and their family members had to express their views. They felt they were able to participate in and supported to make decisions about their care and support. We saw people made choices throughout the day about where they wanted to go, what they wanted to drink and what they wanted to do. Care plans contained information

about people's lives, their social history, hobbies and interests, although some contained more in-depth information than others. This helped staff to know the person they cared for and understand their backgrounds.

We observed at lunchtime, people were shown the food available as well as hearing a verbal description before making their choice. People told us they would have liked a choice of cold meals during the hot weather but this had not been offered. Staff told us people could choose to have a salad if they preferred, but we did not hear this offered to people. We saw a bottle of wine on a shelf in one dining room, but this was not offered to anyone and it remained unopened. One staff member told us people knew they could have wine if they wanted it, but they knew from experience most people would refuse it if offered. This demonstrated staff did not always confirm people's choices with them.

Is the service responsive?

Our findings

At our previous inspection in August 2017 we found the service was not consistently responsive and had rated the responsiveness of the service as requires improvement. At this inspection we still had concerns about the responsiveness of the service.

At our last inspection people did not always get their care needs responded to when they wanted, because there were not enough staff. The manager reported staffing levels had increased, which was supported by our observations of the rota, as well as comments from staff. However, there was still concern that some people were waiting longer than appropriate, for aspects of their care to be delivered. There was a concern regarding the response times to call bells as well as the number of baths/showers being offered to people. One relative told us "things are slowly improving but my relative has not had a proper bath since being here and I think it is because they have not got the staff to cope". We found the records of baths being given did not match expectation from the care plans reviewed. Another person told us: "I am broadly happy here and don't want to move again. There are just not enough staff and there are a lot of people like me who take a lot of looking after."

At our last inspection people and relatives did not feel their concerns were always addressed. Prior to this inspection we had received complaints that people's and relative's concerns were not always addressed or resolved and had been allowed to escalate into formal complaints. We looked at the complaints system and found all the complaints that had come in via formal channels had been acknowledged by the manager, investigated and fed back to the complainant. Where there was fault found the manager did offer an apology and feedback was shared in team meetings. However, we found there was no system in place where people living in the home could have their complaints and concerns recorded and dealt with on a day to day basis. Many of the formal complaints were in response to people consistently telling relatives that they were not happy with something. This in turn had led to relatives escalating the complaint and taking over the dialogue with the provider. A complaints book was situated in the lounge however there was no pen with it, no clear instruction and although it was monitored the lack of recording suggested it was not being utilised to any degree by people living in the home. We discussed this with the manager who agreed that if resident's comments were responded to in a timelier fashion that there would be significant improvement observed in overall satisfaction with the service.

A review of people's care plans demonstrated that assessments were ongoing for people and that professional input was sourced when required. There was evidence that pressure sores were improving for people recently admitted due to the attention given by the staff and the positive relationship with the Tissue Viability Nurses. A number of admissions to the service appeared to have been made as a result of a nursing home bed being needed and therefore the family and the individual had not necessarily made the choice and the admission process was completed in a short time scale. Despite this the home had extensive assessments and care plans in place to cover a wide range of clinical need. Some care plans we reviewed would have benefitted from greater detail to ensure staff knew how to respond to people's individual needs. For example, one person liked walking however her support plan did not contain the detail of how to manage any potential falls risk and ensure a walk was possible.

Throughout the inspection we saw numerous families visiting and spending time with relatives. Some sat in people's rooms with them, some sat in the communal lounge and others enjoyed sitting in the garden. One relative told us that their relative was not very sociable however, "the home had been brilliant at supporting a recent family birthday and had made everyone welcome".

We observed the activities team working with people in the communal areas and saw that there was a plan in place for the week. A review of the activities file demonstrated activities occur both in and out of the house with trips to Cosford air show recorded as well as visits to the home by external entertainers and a range of other in-house events were on offer. Observations did suggest activities were focussed on people who would be sociable and join in with the group. We did not observe lots of social interaction occurring in people's rooms outside of the completion of any care tasks.

At the time of our inspection, no one living at the home was receiving end-of-life care. The provider had procedures in place to identify people's wishes for their end-of-life care, with the input of their relatives, at the appropriate time.

Is the service well-led?

Our findings

At our previous inspection in on 24th August 2017 we found the service was not consistently well-led and had rated this key question as Requires Improvement. At this inspection we still had concerns.

The home did not have a registered manager in post. A new manager had been in post since May 2018 but they had not registered with us yet. They confirmed they would be completing their application to register in the near future because their DBS check had just been completed.

The provider had not made the new manager aware of any improvement action plans being completed by their predecessor. However, the new manager had themselves created an action plan, which they were able to share. The manager confirmed that they completed three walk rounds daily and held regular meetings with the team throughout the day.

Staff were required to complete daily records to confirm the support they had given to people. We found staff did not consistently complete these records. We saw one person's care plan identified they wanted their shower on a specific day each week, which was the day before our visit. We saw no record of this person having their shower but a staff member told us this person had received their shower the previous day. We also saw records for other people's showers and baths were poorly maintained by staff. The manager told us they identified when they first came to the home that this was "not as robust as it should be" and had taken steps to address this.

Some people were unable to use their call bells to ring for help. Risk assessments had been completed which stated their "safety and wellbeing was to be acknowledged at one hourly intervals". One nurse confirmed staff should record their hourly checks on the person's well-being record in their bedrooms. Although staff told us they completed these checks as required, we saw these were not always recorded, especially during the night. Another person's care plan stated staff were to prompt the person to have a shower and if they declined to offer on another day. However, this person's records did not show staff had prompted the person to have a shower, or that they had refused a shower. We also found some care records were illegible and we struggled to read them. When we asked staff to read what was written, they had difficulty too. The provider could not therefore be assured people received care as planned because care records were not completed as required, or were illegible.

People told us that they still had to wait for their care needs to be met even though the staffing levels had been increased since the last inspection. This meant that the provider's dependency tool and audit of call bell response times had not been effective in ensuring that staff were deployed where they needed to be and responded to people in a timely way.

This is the second consecutive inspection where we have rated the home as requires improvement. Despite actions taken and improvements made by the previous registered manager and the new manager, we found some of the same concerns we had identified at our last inspection. At this inspection there was a strong odour in one area of the home. We had identified and spoken with the regional director and the last

registered manager at the time of our last inspection about this same malodour. They had assured us this would be addressed and new flooring laid to replace the stained carpet. At this inspection we found this had not been completed. The new flooring was ordered 6 months after our last inspection, but due to an ordering error this had not included replacement of the bedroom carpets where the staining was located. This was confirmed by the regional director and manager. The manager confirmed to us, after our inspection, this had now been completed. However, this meant the provider had not addressed all issues we raised at our last inspection.

We found storage of people's care records was cluttered in some areas of the home. We also found one person's care file and discussed the person's care with a staff member, before we discovered this person had moved to another home three days earlier. This person's care records did not clearly state the person had been transferred. Dates were missing on some people's care records and not all we viewed were up to date. One person's activities care plan stated they enjoyed walking as an activity. But it did not mention how staff should support them to achieve this when the person was prone to falls and currently walked with a frame. We saw care folders contained so much paperwork they were falling apart and in one office, the desk was so cluttered staff could not easily find information we asked for. We spoke with the manager about this. They told us storage was a recognised issue at the home and the planned home refurbishment would create additional areas of storage. They also told us they had already designated staff to complete a process of replacing folders and archiving records which were not current.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the rating of the last inspection was on display and notifications were received as required by law, of incidents that occurred at the service. These may include incidents such as alleged abuse and serious injuries. These ensure that we are aware of important events and play a key role in our ongoing monitoring of services. However, the provider had failed to notify us of some of the approved deprivation of liberty applications, which had been authorised by the local authority since February 2018. We discussed this with the manager who confirmed these notifications had not been submitted. They took action after our inspection to ensure these were submitted to us retrospectively.

People and their relatives were involved and asked for their feedback about the way the service was managed. Regular staff meetings took place which enabled staff to voice their views about the care and the running of the home. The manager explained that she is sharing information with the team about the improvements needed. The manager suggested that "documentation standards are improving around daily charts and personal care as these are now being checked three times a day." The manager also confirmed that as part of her walk around she is observing health and safety, activities for the day and the residents level of engagement, that bedrooms and communal areas are tidy, that call bells and drinks are in reach, in addition that residents are supported to be presentable and that people are speaking with any relatives,

The manager explained that as part of her work with the team she has introduced an "update sheet" for all staff to have which outlines expectations and the responses to concerns, complaints and any incidents (lessons learnt). The manager informed us that they explained the detail further in daily stand up meetings with the unit managers.

Staff were quoted as saying that their manager was "open and honest about what needs to improve. We are getting there." Another staff member stated that "We are improving as a staff team. The teamwork is improving."

Within the manager's office we reviewed a number of records that demonstrated monthly audits were happening and clinical governance meetings which looked at residents needs and risks took place. These meetings looked at areas such as nutrition, tissue viability, choking, falls, medication and any reported incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The governance systems the provider had in place to monitor and improve the quality of the service had not been effective.