Midland Healthcare Limited

Dove House Care Home

Inspection report

Dairy Lane
Sudbury
Ashbourne
Derbyshire
DE6 5GX

Tel: 01283820304

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 24 and 25 October 2018 and was unannounced. We last inspected this service in June 2016 and rated the service 'Good' overall. At this inspection, we identified concerns that put people at risk of poor and unsafe care. This inspection identified five breaches of the regulations and we have rated the service 'Requires improvement' overall.

Dove House Care Home 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. The care home accommodates up to 42 people in one adapted building. The home is also registered to provide nursing care under some circumstances, however nursing care was not provided at the time of our inspection. We were informed the provider intended to amend their registration to remove nursing care.

There was no registered manager at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently left and a new manager had joined the service just over a week before our inspection. The manager told us they intended to support ongoing improvements to the service and to register with the Commission.

Systems were not effective to ensure people would always be safeguarded from abuse. We also found people were not always supported to have their risks safely managed, including some people's support with their medicines. We also found staff were not effectively deployed to meet all people's needs safely. The concerns around the safety of the service resulted in three breaches of the regulations related to safeguarding processes, safe care and treatment and the deployment of staff.

Feedback from people, relatives and staff showed they generally felt the service was safe. Routine checks helped promote the health and safety of the home. Recruitment checks were in place but not always carried out robustly. People had access to healthcare support.

People's needs were not always effectively responded to, including support with people's meals and drinks. We received positive feedback from most relatives and healthcare professionals about the support provided by staff. Improvements were underway to the support and guidance in place for staff to ensure people's needs were always effectively responded to. Improvements were also required to ensure people were always supported in line with the requirements of the Mental Capacity Act 2005 (MCA).

People's privacy was promoted and we often saw friendly and caring interactions towards people from staff, however this was not consistent practice. People were not always well engaged with and involved in their care as far as possible. Improvements were also required to ensure people were consistently supported to

have their dignity and respect promoted.

Although we received positive feedback in relation to most people's care, people's care and preferences were not always met as far as possible, including around people's access to activities. The provider told us they were driving improvements to the service to ensure people's wishes and preferred routines were known and followed. Systems were not robust to ensure complaints would be used and learned from to improve the quality of the service.

The provider recognised improvements were required to the quality and safety of the service and steps to achieve this were underway. Staff felt supported by management and by the new manager who had joined shortly before our inspection. The ratings from our last inspection were displayed as required.

We identified a breach of the regulations because systems and processes were not effective to ensure the quality and safety of the service. Systems had not identified safety concerns including around recruitment processes and staff deployment, and processes were not always robust to ensure incidents and risks were appropriately responded to. We identified a further breach of the regulations because the provider's processes failed to ensure CQC were notified of all specific events and incidents as required by law.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems were not effective to ensure people would always be safeguarded from abuse.

People's risks were not always safely managed, including some people's support with their medicines. Recruitment checks were in place but not always carried out robustly.

Staff were not effectively deployed to ensure they could meet all people's needs.

People, relatives and staff told us they generally felt the service was safe. Routine checks helped promote the health and safety of the home.

Is the service effective?

Requires Improvement

The service was not effective.

People's needs were not always effectively responded to, including people's support with meals and drinks.

The design and décor of the home was not always developed around people's needs.

We received positive feedback from most relatives and healthcare professionals about the support provided by staff. Improvements were underway to the support and guidance in place for staff to ensure people's needs were always effectively responded to.

People were not always supported in line with the requirements of the Mental Capacity Act 2005 (MCA).

People had access to healthcare support although recent referrals had not been effectively monitored.

Is the service caring?

Requires Improvement

The service was not caring.

Some feedback we received from people and relatives suggested the service was not consistently caring.

We saw that although some staff were friendly and caring, this was not consistent practice. People were not involved in their care as far as possible and were not always well engaged with by staff.

Improvements were required to ensure people were consistently supported to have their dignity and respect promoted.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care and preferences were not always met as far as possible, including people's access to activities and support with communication.

We received positive feedback in relation to most people's care. The provider told us they were driving improvements to the service to ensure people's wishes and preferred routines were known and followed.

People could not be assured that complaints would be used and learned from to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems and processes were not effective to ensure the quality and safety of the service.

The provider's processes failed to ensure CQC were notified of specific events and incidents as required by law.

The provider recognised improvements were required to the quality and safety of the service and steps to achieve this were underway. A new manager had joined shortly before our inspection.

Dove House 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 inspection took place on 24 and 25 October 2018 and was unannounced. The inspection was completed by an inspector, a bank 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 care service. Their area of expertise was the care of people living with dementia.

Before our inspection, the provider informed us of concerns whereby some people had been subject to financial abuse. The provider had informed relevant partner agencies of those allegations and police and safeguarding investigations were ongoing at the time of our inspection. Those allegations are subject to a criminal investigation and as a result this inspection did not examine the circumstances of this. The provider was in the process of reviewing how people were supported with their finances at the time of the inspection to prevent any future reoccurrences.

As part of our inspection planning, we referred to information and feedback shared with us by a local authority quality monitoring team. We also checked whether any information was available from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We referred to other information we held about the service to help inform our inspection planning. This included notifications, which contain information about specific events and incidents that the provider is required to send us by law.

During our inspection, 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. We spoke with five people living at the home and five relatives. We sampled records relating to five people's care alongside other documentation about the quality and safety of the service. We looked at recruitment checks including two staff member recruitment records at random. As part of our inspection we spoke with four care staff, the deputy manager, the new manager, the area manager and the nominated individual. We also spoke with

five healthcare professionals involved in people's care.

We shared concerns identified through our inspection activity with the local authority safeguarding teams and commissioners of the service. The manager shared additional information with us as requested after our inspection.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2016, we rated this key question, 'Good'. At this inspection, we identified concerns including three breaches of the regulations around staff deployment, risk management and safeguarding processes. We have now rated this key question, 'Inadequate'.

Staff were not always deployed to meet all people's needs safely. One person had recently sustained a serious injury following a fall. The person needed to be monitored and encouraged to use an aid when walking to remain safe. We found staff were not present to identify three occasions when the person walked alone without their aid. This included an occasion when the person walked on a potentially slippery surface near to a wet floor sign. We had to find and prompt staff to monitor the person. Staff had not been deployed to ensure this person's safety despite their recent injury and known risks.
In another example, staff were not effectively deployed at mealtimes to support people appropriately. We saw potential hazards including some people's containers of prescribed thickener, were left accessible in the dining room. Staff were not available to address this risk, or respond when some people left the dining room after a short while without eating much of their meals. We saw one staff member supported two people to eat at a time which did not promote a positive experience for either person. Other staff were busy supporting other people. The second person's meal was eventually reheated as it had gone cold over the time they waited. The area manager confirmed there was no system in place to ensure staff were suitably deployed according to people's individual risks and the needs of the service.

Failure to ensure the suitable deployment of staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems had not consistently ensured people would always be safeguarded from abuse. Investigations with relevant partner agencies were underway at the time of our inspection, due to allegations that some people had been subjected to financial abuse at the home. Changes to the provider's systems had helped identify this and the provider had ensured those concerns were reported to relevant partner agencies for further investigation. During our inspection, the area manager described further improvements they had since made to their processes to prevent people coming to risk of harm again.
Staff we spoke with knew how to identify and report possible abuse and had recorded other incidents, however, staff had not all received safeguarding training to ensure they understood how to help protect people. Managers told us staff had been too scared to report that one person had been inappropriately supported before our inspection. This had prevented the concerns being shared with relevant partner agencies in a timely way to protect the person. The provider had since addressed this poor practice and was supporting this safeguarding investigation at the time of our inspection after a previous employee raised concerns. Although work was ongoing at the time of our inspection to improve the safety of the service, recorded concerns and incidents, including altercations between people using the service, were not always thoroughly investigated and learned from to promote people's safety. We shared such concerns identified through our inspection with the local authority safeguarding teams and commissioners of the service.

Systems and processes were not operated effectively to prevent abuse of people living at the home. This is a

breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's risks were not always effectively managed to ensure their safety. One person required foods to prepared in a specific way to reduce their risk of choking. We saw this person was served breakfast which had not been safely prepared as required. Records we sampled showed the person had recently consumed additional foods which put them at increased risk. We brought it to the provider's attention that the person's support needs were not always safely met and monitored as this concern had not been identified. Another person required fluids to be thickened to a specific consistency to reduce their risk of choking. Although the staff member who prepared the person's drinks told us they had a lead role in ensuring people's fluids were prepared safely, they could not tell us the correct consistency the person's drink should be made to. The staff member did not refer to any guidance to ensure they had prepared this person's drink safely.
We saw staff had limited guidance about how to consistently and safely support people at increased risk who required specific support with meals and drinks. The manager sought advice and guidance from the local speech and language team during our inspection to start to address this concern.

Other risks to people's health and safety were not always effectively managed. For example, we saw one person at risk of falls tried to carry and drag their walking frame and did not use this aid safely. On further observation we saw this person's walking aid was not in full working order. Although staff were present, they failed to intervene to encourage the person to walk safely or to report faults to the person's walking aid.

A healthcare professional told us that poor staffing levels in the weeks before our inspection meant some people were not safely supported. This had put some people at risk of developing sore skin and had been raised as a concern with relevant partner agencies. During our inspection, staff told us they followed healthcare professionals' guidance to support one person who had developed sore skin and records we sampled confirmed this. The healthcare professional told us however that previous improvements to manage people's risks were not always sustained. For example, creams which had helped improved some people's conditions previously, had not then been reordered by the home on time to maintain this progress. This healthcare team had recently met with the new manager to discuss how people's risks could be better managed and improvements sustained.

We saw improvements were also required to ensure people were always safely supported with their medicines. Covert medicines administration refers to people being given their prescribed medicines without their knowledge, for example in a disguised form such as with a yoghurt. Some people living at the home received their medicines covertly. Although this decision had been agreed with a healthcare professional, relevant guidance and processes had not been followed to ensure this support was always appropriate and safe. For example, there was no review of how, when and why people's medicines should be given covertly, and when this decision should be reviewed to promote people's independence and safety. We also found concerns that the temperature of the medicines trolley was not monitored and audits had not identified and addressed this. Current good practice guidelines recommend that storage temperatures are monitored to help ensure the efficacy of people's medicines.

Failure to provide safe care and treatment for people, including the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection had found recruitment processes were safe. Staff completed renewal checks through the Disclosure and Barring Service (DBS) to ensure they remained suitable to work with vulnerable adults. A relative spoke positively about their involvement at staff interview panels to help ensure the recruitment of staff with the right values. We found however that some recruitment processes were not always carried out

robustly. Two staff files we sampled showed both staff had undergone character reference and DBS checks before they started in their roles. However, our sample of records found that reference checks were not always carried out with two referees and by previous employers wherever possible. We also found risks were not appropriately assessed and documented for some current staff whose DBS checks had identified concerns. We were informed on inspection that this would be addressed and after our inspection, the provider advised that all relevant risk assessments were in place and stored appropriately.

Feedback from people, relatives and staff showed they generally felt the service was safe. For example, one person told us, "I like it here. I have no worries and I feel safe." We saw some people's risks had recently been reviewed with input of healthcare professionals to improve the safety of their care. For example, one person's medicines had been reviewed and staff had recently received training related to their needs. We saw the number of incidents involving this person had since decreased. People were supported to take their medicines by trained staff. We saw staff kindly supported people at their preferred pace and monitored to check people had taken their medicines. Medicines were securely stored and records we sampled correlated with the medicines stock available.

A relative told us they felt the home was kept clean. We saw domestic staff were employed to help maintain this. Health and safety checks were also routinely carried out to help reduce risks posed by the environment. This included regular fire drills, and external fire safety checks which had led to agreed improvement plans. Records related to health and safety checks were kept updated.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in June 2016, we rated this key question, 'Good'. At this inspection, we found improvements were required to ensure people's needs were always effectively responded to, including through timely referrals for healthcare support and training provided to staff. Improvements were also required to ensure people were supported in line with the Mental Capacity Act (2005). We have rated this key question, 'Requires improvement'.

People's needs were monitored with input from healthcare professionals to promote their health. One person told us, "If you need to see the GP then it is arranged and there is a chiropodist who comes every 8 weeks or so." Another person went to hospital after staff reported concerning symptoms. A relative told us, "It's a good team, any problems they always ring me up." A healthcare professional also visited the home on a weekly basis, as part of an initiative with the local authority to reduce hospital admissions. Healthcare professionals we spoke with confirmed staff contacted them if they had concerns and made appropriate referrals. We found however that where some people had recently required referrals to access further healthcare support, this had not been effectively monitored to ensure those referrals were timely. For example, although we were told a falls clinic referral had been made for one person, this was not documented or followed up after additional falls the person suffered. Referrals for further healthcare support were being made for some people at the time of our inspection to help address this.

We received positive feedback from most relatives and healthcare professionals about the support provided by staff. One healthcare professional told us, "Staff we work with particularly, senior staff are always very friendly and always have people's best interests at heart." Staff we spoke showed some understanding of people's needs and told us they felt supported. Staff handovers covered relevant information to help monitor people's needs. Staff had received training in some relevant areas such as safe moving and handling, fire safety, basic life support and infection control. Further improvements were required and underway however as staff did not all have the necessary skills and guidance for their roles. Most staff had not received the provider's training around pressure care and falls prevention, to help ensure staff understood how to effectively support people who were at risk of harm related to those needs. Some staff who had recently received training around how to support people when they became distressed, told us they now felt equipped and confident to respond effectively. However, staff did not have a consistent and effective response when some people became distressed. One person living with dementia was confused and spoke negatively to another person throughout lunchtime. Although a staff member witnessed this interaction, they did not intervene or assure either person. Our sample of records also found that staff inductions had not covered all elements of the Care Certificate. This is a requirement for staff who are new to care roles. A trainer supported staff with coaching and training as part of the provider's ongoing planned improvements in this area. The trainer was also planning training tailored around people's needs and told us they had amended some training focus areas based on our inspection feedback. The manager told us they had prioritised supervision sessions for staff and sourced further training and current good practice guidelines to share with staff. A healthcare professional confirmed, "There seem to be positive management changes and their role in supporting staff. The area manager is looking at upskilling staff and ensuring competence."

The provider told us people's weights were monitored monthly and nutritional supplements were prescribed for some people at increased risk of weight loss. The manager told us a sweets trolley was being purchased shortly after our inspection to encourage more snacks and foods of higher calorific value. Whilst we saw some people enjoyed positive mealtime experiences, this was not consistently promoted across each meal time and over both days of our inspection. Improvements were required to ensure people always received the support they needed with meals and drinks. Managers told us the safety concerns we had brought to their attention around this aspect of people's care would be addressed. During lunchtime, people were not always encouraged to eat enough, for example, staff cleared some people's plates away without their permission and when some meals had not been touched. This was because staff moved on to serving desserts. We observed more appropriate support with people's breakfasts. People were served breakfasts of their choice, when they wanted it over the course of the morning and people finished their breakfasts. One person told us, "The food is good and there is enough of it too. If you didn't like something, then I think they would change it." Another person told us, "The food is very nice. It is brilliant here." People were served well presented meals, with healthy options available. The manager told us they had plans to encourage more snacks and increase people's fluid intakes to drive further improvements in this area.

Improvements were also required to ensure the home was design and developed around all people's needs. Areas of the home were pleasantly decorated and welcoming and a relative commented, "The overall experience is good, I like it, it suits [one person's] needs. [Person] lives with dementia but they walk and there's plenty of room to move around". However, communal areas and corridors where some people spent much of their time were not designed to enhance people's experiences. Signage and pictorial aids were not used to help navigate people and although managers were aware of current good practice such as the use of tactile items, these were not used to help stimulate and engage people. We saw people used equipment, for example to help them move safely around the home, however a healthcare professional told us some equipment could not always be prompted located although people regularly needed this to help manage their risks.

Improvements were required to ensure people were always supported in line with the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff we spoke with understood people's rights and how to support people to make their own decisions. We saw people's choices were often respected, for example, if they did not want to be supported. However, this was not consistent practice and we saw occasions where some people's consent was not sought before they were supported. Some decisions about people's care had been agreed with relatives and healthcare professionals, for example, for medicines to be administered covertly. This decision was not recorded and reviewed to establish whether it was in the person's best interests.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We saw people were appropriately supported, for example, some people walked freely around the home and staff told us they diverted some people, for example, with alternative activities when needed to ensure people's safety. However, one person had recently been subject to restrictive support by staff who had been concerned about the person's risk of falls. This had put the person at risk of harm and did not promote their dignity. Although the provider had since ensured all staff understood this support had been inappropriate, staff had not been suitably deployed so that alternative support for the person could always be provided as planned to ensure their safety. The provider's systems

had also not effectively monitored people's DoLS applications and authorisations. Documentation related to this was outdated and we brought it to the provider's attention that one person's DoLS authorisation had expired on the day of our inspection, as their own systems had not identified this.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in June 2016, we rated this key question, 'Good'. At this inspection, we found that people were not always involved in their care as far as possible and engaged with well, and staff were not consistently caring. We have rated this key question, 'Requires improvement'.

Although some relatives were involved in people's care where appropriate, people were not always well engaged with and involved in their own care decisions as far as possible. One person told us, "They don't really discuss my care with me, I'm not sure I have had any care reviews." Another person told us they were not supported with personal care how they wanted to be: "[Staff] don't ask my opinion and I don't like the way they do it." On the first day of our inspection, this person also told us, "I don't like the slop they give me all mushed up," in relation to their meals. Although we shared this feedback with management on the first day of our inspection, the person's lunch was prepared in the same away again on the second day of our inspection. The person gave us similar feedback again and they were eventually offered an alternative when they didn't eat this. The person's feedback had not been appropriately addressed.
This was an area of improvement that the provider had identified through their own oversight and had started to address. A healthcare professional confirmed, "It's got a lot better in terms of involving people more, this is evident in practice." Relatives told us they had some input in people's care. One relative told us they had been involved in two care reviews, and commented, "They tell me how [person] is doing." Another relative told us, "We're kept involved, very much, it's very good."

Staff did not demonstrate a consistently caring approach and some people's feedback reflected this. One person told us, "On the whole the staff are kind. Some more than others. There has never been any rudeness." Another person told us, "I did complain about the attitude of one staff member who was very sharp with me and they dealt with it. It seems to have been resolved." We saw occasions where some people's call for support or to chat were not always responded to. We saw one person was ignored by a staff member when they asked for a drink. The staff member left the room without answering the person. Another staff member who witnessed this, assured the person they would be given a drink.

Staff did not always take opportunities to engage well with people whenever possible. One person told us, "Staff need to be a bit more civil. It is a hard job for them but I spend all day sat on my own." We saw one person was startled when a staff member moved the chair the person was sat in, and gave the person food without seeking their consent first. This did not demonstrate respect for the person and was a missed opportunity to socialise with the person. Although some staff were warm and attentive in their approach, we saw little spontaneous interaction with people from other care staff.

People were not always treated with dignity and respect. One person was discouraged from accessing an unsafe area of the home by a staff member. The staff member repeatedly called the person and told them, "Come with me" from a distance. The person eventually moved towards the staff member and said, "What have I got to do." The staff member was busy engaged in other tasks and left the area once they were satisfied the person was safe. The person was not kindly reassured or engaged effectively. We saw some less independent people were left with food spillages on their attire and tabards throughout the morning after

breakfast. This did not promote their dignity.

During our inspection, we also saw some staff were often friendly and caring towards people and feedback we received also reflected this. One person told us, "We like the staff and they are fine with us." A healthcare professional told us, "Staff genuinely do love their residents and you can see that. They give hugs and I think it's lovely. I find it really nice." A relative told us, "Staff are caring from what I see. I'd be the first to say if not." People were supported with their medicines patiently and enjoyed a chat with a senior staff member at this time. Another staff member joked with one person who responded well to this. Staff described kind ways they supported people and spoke about people respectfully. A relative told us, "Staff are very kind generally, most of the time." When staff were able to spend time with people, we saw they often responded with reassurance and patience, for example when some people living with dementia raised repeated issues or questions. We saw a staff member reassured a person effectively when they were upset. The staff member told them, "What's the matter? Smile for me, that's better you've got a lovely smile, you really have."

We saw some people enjoyed one another's company and spent time together. For example, two people walked around together and chatted throughout the day. Another person told us, "I have made friends here. I like the staff." Some relatives regularly visited the home and we saw they were well known to staff. One person told us, "If I have any worries I can talk to my carer so I have a friend if I need one." Another person responded well to a staff member who chatted to them about their relatives' recent visit. Relatives could visit people when they wanted to which helped people maintain relationships that were important to them.

We saw that people were well dressed in clothing suitable for the weather and were individually dressed in well fitted clothes. We saw that most people had been supported with personal grooming. Staff member saw one person was uncomfortable and supported them until better. There was a hairdresser who took several people to have their hair styled. People were often approached and their consent sought before they were supported. Staff knocked on bedroom and toilet doors before entering to support people. This helped promoted people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June 2016, we rated this key question, 'Good'. At this inspection, we found people's care and preferences were not always met as far as possible, including people's access to activities. Complaints were not always used effectively to improve the quality of the service. We have rated this key question, 'Requires improvement'.

People and relatives spoke positively about an activity coordinator who had been recently recruited. Some activities were offered including board games, group activities, and some people enjoyed having their hair styled by a visiting hairdresser. Managers described plans to celebrate an upcoming festive period along with opportunities to engage the local community.
However, people's abilities and preferences had not always been considered to provide people with good access to activities. People who spent their time in communal areas did not have access to resources to engage them, for example to read, or tactile items. One person tidied spillages and bowls from tables and tried to draw the curtains. This was a missed opportunity to give the person occupation. Although managers told us they had introduced '11 minutes at 11am' as protected time for people and staff to chat and spend time together, we saw no evidence of this and some people were often left without interaction or activity. In another example, management had informed us that nobody had specific communication needs due to a sensory impairment. One person's feedback showed their needs had not been considered as they told us, "I love reading but I can't see so my family bring me audiobooks from the library. There isn't anything like that here. There are no activities to take part in really. I can't see anyone's faces."

Some people were supported to have their communication needs met. For example, a relative told us, "[Person] doesn't talk now, but staff respond well." However, this was not a consistent experience and although some people required additional support, we saw no tools in use to help people to communicate their wishes. For example, there was no accessible materials such as pictorial menus to help people identify menu options. Some people could not use the menus available and could not recall what meal was about to be served.

Most people and relatives described positive experiences and told us they would recommend the home. People were supported at a pace that suited them for example to move around the home and when supported by staff. Care records we sampled often showed some information about people's needs and preferences had been gathered with input from people and their relatives. However, processes had not always been followed as planned to ensure people's needs and preferences were always met. Our discussions with healthcare professionals and the provider found some people had been inappropriately admitted to the home as their needs could not always be safely met. The provider told us this was because admissions assessments had not always been carried out effectively, and they had since updated these processes. A healthcare professional confirmed the provider had improved how some people were supported to ensure their safety and comfort, and some people were supported to move on to more suitable placements. Improvements were required to ensure care planning processes records captured and reflected all people's current needs and preferences. For example, some records we sampled did not always detail appropriate support for people living with dementia and what activities people enjoyed.

The provider also told us they were aware of recent concerns that people's preferences had not always been sought and considered, for example, people had not always been supported to have their meals how and when they wanted. The provider had started to rectify this to improve people's experiences. People spoke positively about this and told us they got up at times that suited them. One person told us, "We can get up when we want to and go to bed when we are ready. It is a very easy going place." Another person told us, "I get up when I want and they encourage me to so that I don't get a bad chest." We saw another person left their breakfast tray outside of their bedroom for collection. The person responded back positively when the deputy manager called out to wish them good morning.

People we spoke with told us they had not needed to complain. Relatives told us they felt able to complain and staff told us they addressed people and relatives' minor concerns whenever they could. People and relatives told us they would speak to staff and management if they had concerns. We also saw information about how to complain was on display, although this was not in accessible formats to ensure all people knew how to complain.
We found that further improvements were required to ensure people and relatives' feedback, complaints and concerns would always be used to improve the quality of the service. A relative told us their increasing concerns had not been acted upon in relation to poor support one person received. Another person's relative told us they had questioned staff about a concern but had not received a clear response. We prompted for those issues to be addressed during our visit. Records we sampled showed formal complaints had been logged and addressed, however there was no evidence of analysis and learning taken from this feedback to improve the quality of the service.

Nobody living at the home required end of life care at the time of our inspection. Conversations about some people's needs and preferences had taken place with the support of a healthcare professional. A relative confirmed they had been involved in similar discussions and a staff member was aware one person may soon require this level of care. Another person's records we sampled showed their care wishes had not yet been gathered and the deputy manager showed consideration that this was a sensitive discussion to be approached with delicacy. Systems were in place to help ensure people would be supported as they wished at their end of their lives.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in June 2016, we rated this key question, 'Good'. At this inspection, we identified a breach of the regulations because systems and processes had failed to ensure the quality and safety of the service. We identified another breach because the provider had not notified us of events and incidents as required by law. We have rated this key question, 'Requires improvement'.

Before our inspection, the provider informed us they had identified some people living at the home had been subject to financial abuse. Changes to the provider's systems had helped identify this. The provider followed appropriate processes and ensured relevant partner agencies were alerted to the concerns. The provider had since improved their systems so that any support people received with finances were appropriately monitored. This would prevent any further incidences of financial abuse to people in their care.

The provider had not identified and addressed that recruitment checks were not always clearly documented to ensure these processes remained safe. Where some staff recruitment checks had prompted possible concerns, the previous registered manager had stated they were satisfied that staff were suitable for the role without completing appropriate risk assessments. In another example, the provider did not have effective systems in place so that staff were suitable deployed according to people's individual needs. We saw this impacted the quality and safety of people's experiences. For example, staff were not available to support people when using walking frames around the home. One person told us this made them feel less safe and we saw other people were at increased risk of falls. Although after the first day of our inspection the provider told us this would be addressed, we identified similar concerns and lack of staff visibility again on the second day of our inspection.

Audits were not in place to ensure people's identified needs could always be safely met. The area manager had completed audits to help oversee the quality and safety of the service. Although those audits had identified some changes to people's needs and risks, this had not always led to clear action to help effectively assess and monitor those risks. The provider had also failed to maintain clear guidance in relation to how some people's food and drink should have been prepared to prevent their risks of choking. Staff showed inconsistencies in their understanding of people's support needs and we saw this had put people at risk of unsafe care. One person's care records showed they had been served foods which presented a choking risk but audits were not in place to help identify and rectify this. Although work was ongoing at the time of our inspection to improve the safety of the service, incidents had not always been thoroughly investigated and timely action taken to ensure people's safety as far as possible. Staff had reported incidents where people had come to risk of harm, for example due to altercations with other people living at the home. Records we sampled showed reactive action was taken but ways to prevent future reoccurrences were not considered. For example, although incidents of one person who suffered several falls were recorded, none of the incident forms we sampled had been appropriately reviewed to help identify how to ensure the person's safety at all times. The provider confirmed this person had been inappropriately supported by staff who had tried to prevent the person from falling.

Systems and processes were not effective to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to ensure CQC were notified of incidents and events as required by law. Incidents and concerns where people had come to risk of harm had often been notified as required to the local authority, however CQC had not notified. The provider's audits had not identified this. The new manager showed understanding of events that were notifiable to the Commission and sent through retrospective notifications after our inspection.

Failure to notify the Commission of specific events and incidents is a breach of Regulation 18 of the Health and Social Care 2008 (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is finalised.

The provider and managers were open and frank with us that the service needed to improve and felt this could be achieved further to recent management changes. Other improvements had been initiated to improve the quality and safety of the service and steps were taken to respond to concerns we raised during our inspection. The new manager who had joined the service just over a week before our inspection, told us they were supported by the area manager who regularly visited the home.

The manager described plans to improve people's experiences and opportunities to engage, with reference to a befriending service, the Alzheimer's Society and other current good practice initiatives. The manager had plans to arrange regular residents' meetings to help gather and use feedback from people and relatives to improve the quality of the service. Our discussions with the provider and managers showed understanding of their regulatory responsibilities, including the Duty of Candour and the ratings of our last inspection were displayed as required.

Healthcare professionals shared similar concerns about previous management and felt that improvements were underway to the leadership of the home. One healthcare professional told us, "The previous manager never listened to our concerns, they were shut down. We have an open and honest relationship with the new manager. The culture of the service still needs a lot of work but there does seem to be positive changes making that happen and support for staff." Staff spoke positively about the management of the service and told us they felt supported. Care staff told us they found the senior staff approachable. A staff member told us they initially worked at the home through an agency but they had stayed on long term as they loved the role. The provider and managers wanted to introduce initiatives such as employee of the month, to help staff feel valued further to recent management changes.

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 Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to provide safe care and treatment for people, including the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to prevent abuse of people living at the home.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Notice of proposal issued and subject to possible representations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure the suitable deployment of staff.

The enforcement action we took:

Notice of proposal issued and subject to possible representations