Red Oaks Healthcare Limited

Red Oaks Care Community

Inspection report

116 Clipstone Road West
Forest Town
Mansfield
Nottinghamshire
NG19 0HL

Tel: 01623644195
Website: www.redhomes.com

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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

Red Oaks Care Community is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Red Oaks Care Community provides accommodation, nursing and personal care for up to 40 older people and younger adults. The service provided care to people living with a range of physical and mental health conditions, including some people living with dementia and acquired brain injury from accidents or stroke. At our last inspection in December 2016 the service was rated as Good.

We carried out this inspection on the 22 and 26 February 2018. At the time of our inspection there were 33 people living at the service. This included 29 people who received nursing care.

There was a 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run. Since our inspection the provider has informed us the registered manager has now left the service and a new manager has been appointed.

People's safety from risks associated with their health conditions or some equipment used for their care was not always consistently ensured. Related care and safety improvements were either, made or in progress following recent local authority safeguarding investigations concerned with people's care at the service.

Overall people and relatives felt people were now safe at the service. People and their relatives knew how to raise any concerns they may have about people's safety but sometimes experienced delays before these were dealt with by the provider.

Staff knew how to recognise and report suspected harm or abuse of any person receiving care. Revised care incident reporting measures were recently introduced, which staff now understood. This helped to protect people from the risk of harm of abuse.

The provider had not always ensured sufficient or timely staff planning and deployment arrangements to meet people's changing needs. Recently revised staffing arrangements and additional staff recruitment helped to reduce any risk to people from insufficient staffing.

The provider followed required staff employment and nurse professional registration checks. This helped to ensure staff were safe to provider people's care

Improvements were made to ensure people's medicines were safely managed. However, the provider was

not proactive to ensure this until relevant external authorities concerned with people's care had asked them to.

The service was clean and well maintained. The provider's arrangements for cleanliness, infection prevention and control helped to protect people from the risk of acquired health infection. Staff were not always provided with relevant safety equipment relating to people's care in a timely manner.

People were able to move around the home safely and independently with sufficient space and relevant equipment to enable them to do so.

Staff were not always trained, informed or supported to ensure people always received effective and consistent care.

People were not always supported to maintain their health in a timely or consistent manner. Related records were not always accurately maintained to help ensure this. Management improvements to rectify this were was not yet fully completed or shown to be maintained.

People were supported to have the required type and consistency of food and drinks they enjoyed.

People's care plans showed how their consent or appropriate authorisation was obtained for their care. Best interests' decisions were made for people's care when required, but not always accurately recorded. We recommended the provider seeks further support and training to ensure this.

Staff did not always ensure people's dignity, comfort, choice and independence in their care. Staff usually ensured people's privacy when required.

People and relatives were involved in agreeing some aspects of people's individual care but not actively consulted in relation to service planning for home life or informed to access independent advocacy services if they needed to. Friends and family were made welcome and free to visit people at the times people chose.

Environmental adaptations often promoted people's independence and orientation but service information was not always accessible to people in a format they could easily understand. We recommend the provider reviews their service information against nationally recognised information standards for people who may benefit from this

People did not always receive individualised, timely care from staff in a way that was meaningful to them. People's views about their care, daily living and lifestyle arrangements were not regularly sought or acted to ensure this met with their needs and choices.

People and relatives were informed and knew how to make a complaint if they needed to. Some experienced delays before their concerns were acted on and resolved. Complaints records were not effectively monitored or accurately maintained to consistently show how their resolution was achieved.

The provider's systems and arrangements to check the quality and safety of people's care and to consistently drive and ensure service improvements when required were not effective. This meant people were not always protected from risks associated with the ineffective monitoring and evaluation of the service.

The provider had displayed their most recent inspection rating and related report summary as required. The

provider had sent us written notifications informing us of important events when they occurred at the service. We are liaising with the provider following information received after our inspection that the registered manager no longer works at the service.

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

This is the first time where we have rated the service as 'Requires Improvement.'

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's safety from their health conditions, care equipment; unsafe medicines and staffing arrangements, were not always managed effectively. Related care and management improvements were either made or in progress to help ensure the safety of people's care at the service, following local authority safeguarding concerns about this.

Required staff employment and professional registration checks were made to ensure staff were safe to provide people's care at the service.

The home was clean and generally well maintained. Relevant space and care equipment was provided for people's safety and independence; with a recent delay in the replenishment of required waste disposal equipment for staff safety.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always trained, informed or supported to provide people with consistent and effective care, or to support people in a way they could always understand. People's consent or appropriate authorisation was obtained for their care but related best interest decisions made when required were not always accurately recorded.

People were provided with a choice of food and drinks they enjoyed of the type and consistency needed for their health requirements; but this was not always accurately recorded or monitored when required

Following concerns raised, the provider was working with the local authority to make care and related record keeping improvements, to reduce risks to people from receiving inconsistent or ineffective care. However, this was not yet fully completed or shown as maintained.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity, comfort, choice and independence were not always fully ensured. Staff usually ensured people's privacy when needed.

People and relatives were involved in agreeing aspects of people's individual care not actively involved in service planning or informed to access independent advocacy services if they needed to.

Friends and relatives were made welcome at the home and free to visit at any time chosen to suit the person.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive timely, individualised care from staff or to help ensure their understanding and independence when required. People were not consistently consulted or supported to engage in occupational and recreational activities of their choice

People's inclusion, independence and orientation was promoted by some service information and environmental adaptations. Service information was not always accessible to people in a format they could easily understand.

People and relatives were informed how to make a complaint but some had experienced delays before their concerns or complaints were acted on to their satisfaction. Complaints records were not always accurately maintained to show how they were resolved.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People were not always protected from risks associated with the ineffective monitoring and evaluation of the service. Management and care improvements needed were not always proactively determined. The provider did not consistently ensure the quality and safety of people's care, related record keeping and staffing arrangements.

The provider's arrangements for the governance and oversight of the service were not wholly sufficient to drive ongoing and necessary care and service improvements when required. The

provider had notified us about any important events that happened at the service when required.

Red Oaks Care Community

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.'.

Before our inspection the local authority shared information with us relating to safeguarding concerns they found at the service, which they had investigated with the provider. This found where improvements were needed for people's care and safety. From this, the provider had produced an action plan to demonstrate how this would be achieved. This was being monitored by the local authority.

For this inspection we did not ask the provider to send us their completed Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with local community professionals and care commissioners and looked at all of the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

This inspection was unannounced and carried out on the 22 and 26 February 2018 by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with eight people who lived at the home and two relatives, and observed staff interaction with people. We spoke with six care staff, including one senior care staff member and a cook. We also spoke with the registered manager [nurse] and an external regional manager for the provider. We looked at four people's care records and other records relating to how the home was managed. This included medicines records, meeting minutes, checks of the quality and safety of people's care and related service improvement plans. We did this to gain people's views about their care and to check that standards of care were being met.

Requires Improvement

Is the service safe?

Our findings

The provider was working to make care improvements following recent safeguarding concerns raised with them by the local authority. Their related investigations found concerns relating to staff communication for incident reporting, safety, staffing arrangements and the management of risks to some people's safety associated with some people's health condition or equipment use.

We found approaches to peoples' positive behaviour support had not always been timely or sufficient to inform and ensure people's safety and also staff safety at the service. There had been a high number of safety incidents relating to some people's behaviour that could sometimes be challenging for others. Incidents were not always reported by staff in a timely manner or regularly reviewed by management for trends and patterns, to help inform people's care and related safety needs.

Management improvements were introduced, which included revised communication and incident reporting procedures for staff to follow. Management monitoring records we looked at showed this had led to improvement in the consistency and timeliness of incident reporting when required, although this was not yet sustained. Remedial action was also taken following a recent safety incident to ensure the availability of room master keys to enable staff access in the event of any emergency. This helped to ensure people's safety.

Care plan records did not always provide sufficient instruction for staff to follow to ensure people's safe care and treatment. This related to people's nutrition, skin care and correct use of their electronic pressure relieving mattresses when required. This meant there was a risk to people from receiving inconsistent or unsafe care. Management improvements were in progress for the comprehensive review of people's risk assessment and related care planning documentation. This included timescales for achievement and who was responsible.

A daily management checklist was recently introduced to help monitor people's known health or equipment risks. This was communicated at staff handover meetings held at each staff shift change. Care instructions were issued, which staff were now following to ensure the correct use of any electronic pressure relieving mattress equipment. A revised induction procedure was also recently introduced for any agency staff working at the home; to ensure they fully understood any risks to people's safety from their health conditions, environment or equipment used for their care. This helped to ensure people's safe care and treatment.

People, relatives and staff, including the registered manager felt there had not always been sufficient staff to provide people with timely, safe care. One person said, "We have buzzers in our rooms; staff come if you need them; they can come quickly, but it depends how many staff are on." A relative said, "It's average here; there's not always been enough staff." Staff said people were sometimes left unsupervised in communal lounge areas when they needed to provide people's care privately in other areas of the home, such as in their bedrooms or bathrooms. This included care for a significant number of people who needed at least two staff for their personal care and related safety needs.

The registered manager advised the provider had recently agreed to employ additional nursing and care staff sufficient to provide people's care. New nursing and care staff were either recruited to post with imminent commencement dates, or awaiting completion of professional nursing registration checks were relevant and employment checks. This included checks with the governments' national vetting and barring scheme (DBS). The DBS helps employers to make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups of adults or children. Records showed agency nurses were recently used to provide two nurses throughout the day instead of one. Following consultation with staff, a revised staff rota system was planned for imminent introduction. This helped to ensure sufficient staffing arrangements for people's care.

The provider did not proactively ensure people's medicines were safely managed. The registered manager showed us their action plan, following recommendations from the local care commissioner's pharmacy and medicines management checks at the service in December 2017. Management actions recorded on the plan showed related medicines improvements were mostly completed. However, although people's medicines were secure, storage space was congested, which included some unused medicines waiting overdue for return or disposal. We discussed our findings with the provider's regional manager who has since told us about their action to rectify this.

We observed delays for some people receiving their medicines because of the time it took the nurse to give them. The nurse explained they noted any delayed times to ensure the correct time intervals before giving people the next dose prescribed; which we later observed they followed for people's safety. Instructions for medicines to be given at times, which needed to be strictly adhered to, were followed. For example, at a specific time interval before a person's meal. The regional manager has since told us they have revised their arrangements for people's medicines at the service to ensure timely administration.

People said they received their medicines when they needed them. One person said, "I take pain killers for my arthritis; staff always bring them on time, which is good." Another person told us, "I have a few pills three to four times a day; staff responsible for giving them to me always do this correctly so I don't have to worry." We observed the nurse giving some people their medicines. They did this safely, in a way that met with recognised national guidance for the administration of people's medicines. Some people were prescribed medicines to be given at the times they needed them rather than regularly. For example, pain relief medicines. We saw the nurse took time to check with people if and when they needed this medicine. Medicines administration records we sampled were accurately recorded. This included for two people who could not always say when they needed their pain relief medicines because of their health conditions. Written medicines protocols were in place to show staff responsible for people's medicines what, when, why and how much medicine needed to be given. This showed people received their medicines consistently and safely.

People said they felt safe at the service and made many positive comments about this. One person said," I feel very safe here; staff are kind, efficient and look after us; they wouldn't let anything happen to us." Another person told us, "It's a very nice home, I feel safe; I have two carers with me when I walk, as I can't walk well due to my knees, they support me and make me feel safe." The provider's complaints record showed staff had not always acted in a timely manner when a relative raised their concern about one person's safety. Whilst this was subsequently addressed to the complainant's satisfaction and with no harm to the person; there had been a staff communication delay in fully ensuring the person's safety as agreed with the complainant. People and relatives knew how and were confident to raise any concerns they may have about people' safety at the service but were not wholly confident these were always listened to. Staff were trained and knew how to recognise and report suspected or witnessed abuse of any person at the service if required.

Equipment provided for people's care was regularly checked and serviced to ensure safe use. There had been a recent delay in the replacement of some equipment required for people's care and safety. This included sharps bins required for the safe disposal of any used sharp equipment, such as used injection needles. This had been rectified, with revised management arrangements to help prevent any reoccurrence.

One person said, "The home is really clean and my room; staff wipe down my wheelchair and are very strict about wearing gloves and aprons when they help me to go to the toilet." Another person said, housekeepers dust all my books and keep my room spotless." We observed the environment and equipment used for people's care was clean, maintained and free from any observable hazards. Staff were provided with guidance, training, information and the equipment they needed for cleanliness, infection prevention and control at the service, which they followed. Emergency contingency plans were in place for staff to follow in the event of any emergency in the home. For example in the event of a fire alarm. Routine fire safety checks and staff fire drills were being regularly undertaken and recorded. This helped to ensure people's safety at the service.

Requires Improvement

Is the service effective?

Our findings

People and relatives felt staff often, but not always understood people's health conditions and related care needs. One person said, "We have had a lot of staff changes; new staff usually work with another staff member who has been here a while; but it can be worrying sometimes when staff don't know what they are doing." One person's relative felt recent staff turnover had sometimes affected how well staff knew people and said, "I think most staff are aware of my relative's [specified health] care, but it worries me not all of them are." Another relative said, "Some staff really understand my relative is showing signs of infection, but others just don't seem to be aware and don't have a clue."

Staff were not always trained to ensure people consistently received effective care. Many people had complex health and related care needs. Staff were not able to describe a consistent or informed care approach for some people living with dementia or an acquired brain injury. This included for people's positive behavioural support, related behaviour management and communication needs. Staff had not received related training for this to help them understand and provide people with consistent, informed or effective care. This resulted in some people receiving inconsistent and ineffective care, which they did not understand.

Staff did not feel fully supported to access training and qualifications to progress. Staff training records showed gaps in areas of staff training deemed necessary by the provider, including training updates where required. This included continence and pressure area care, record keeping and information governance, mental capacity and consent. Moving and handling and first aid training was also required for some staff, although this was planned to take place at the service during March and April 2018.

This was a breach of Regulation 18(2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider was working with local authority care commissioners to address concerns raised about some people's care at the service. This was because the provider did not always ensure effective management monitoring and evaluation of people's health and related care needs, including accurate care record keeping. The registered manager showed us their management plan to address this, which showed improvements required were either completed or in progress. We looked at three people's care plans recently revised from this. These provided comprehensive up to date information for staff to follow for people's nursing and personal needs and associated care requirements for their health and nutrition. This helped to mitigate the risk to people from receiving ineffective care. However, the improvements were not yet fully completed or maintained.

A daily checklist was also recently introduced to monitor and inform staff of people's health status, related care needs and any changes required. This was communicated at staff handover meetings held at each staff shift change. Staff we spoke with understood people's related health and care needs for their nutrition, skin and wound care. Recent records from a visiting external health professional concerned with one person's wound care showed this was effective.

We checked whether the provider was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were not always trained and had not always understood or followed the Mental Capacity Act 2005. Some recent management improvements had been made to address this. People's care plans showed how either their consent or appropriate authorisation was obtained for their care. People's care plans mostly showed any best interest decisions for their care where required, although these were not always accurately recorded. For example, two people who were not able to give their consent, had sensor mats in their own rooms to alert staff to their movement at night when they were at risk of falls. A related risk assessment was in place for their use, which staff understood and followed for people's safety. However, best interest care plans relating to people's safety did not specify the decision made for use of the sensor mats or the reason for this. We recommend the provider seeks support and training for the recording of any best interest decisions for people's care.

Some people's freedom was being restricted a way that was necessary to keep them safe and in their best interests. This meant they were subject to continuous supervision to prevent them from leaving the service alone. Appropriate action to seek formal authorisation for people's individual restriction (DoLS) had either been obtained or sought from the relevant local authority where required.

People were supported to eat and drink sufficient amounts. People told us they enjoyed their meals and were offered a choice with regular drinks each day. One person said, "I enjoy the meals; we have a choice, so there is always something I can eat." Another person said, "The food is really very good, nice and homely; I enjoy it." Another person told us how staff were supporting them to make appropriate meal choices to help achieve a healthy body weight and said, "The food is good; care staff are really helping me with this."

Staff knew people's dietary needs, preferences and followed relevant instructions from external health professionals concerned with people's dietary needs where required. For example, the type and consistency of food to be provided for people with swallowing difficulties because of their health condition. Some people needed the amount of drinks they took each day to be closely monitored, measured and recorded to make sure they were drinking enough for their hydration. Related records for this, known as fluid intake charts, did not provide instructions for staff to follow to help ensure people's required minimum daily fluid intake. The provider's management checks were not effective because they did not identify related improvements needed. We discussed our findings with the registered manager who has since told us about their action to rectify this.

At lunchtime we observed staff supporting people to eat their meals. Two were not supported to move to a more comfortable position to fully enjoy their meal. One person who may benefit was not provided with relevant adapted crockery to enable them to eat their meal independently. The person was unsuccessful in their initial attempts to eat independently, which resulted in staff giving them full assistance to eat their meal. This meant the person's independence was not always promoted or ensured.

A range of shared environmental facilities were provided, which included communal lounge and dining

areas and a quiet lounge for people's access and use. People were able to move around the home safely and independently. Sufficient space enabled people to pass safely and have room to use equipment such as walking aids. Corridor hand rails and the use of appropriate signage, such as large picture signs, helped to enable people's independence and orientation. People said they were comfortable and satisfied with their environment.

Requires Improvement

Is the service caring?

Our findings

Staff often did not always ensured people's dignity, comfort, choice and independence in their care. People and relatives felt staff were kind, caring, respectful and often ensured people's dignity, choice and rights when they provided care. One person and a relative told us they had witnessed occasions when people's dignity had been compromised. This included people not always being supported to go to the toilet at the time they asked for staff assistance and staff leaving people with dirty finger nails.

We observed some occasions where people's dignity was not always ensured. For example, staff did not recognise when they needed to adjust one person's clothing and continence wear for their dignity after supporting them with their personal care. Staff assisted the person to move into their lounge chair by using a hoist. When this was completed staff left the person with a drink and call bell to hand, in a semi reclined position for their comfort. However, the person's lower under garments and continence wear were fully exposed and visible to others seated nearby, which compromised the person's dignity. We observed another person had thrown back their bedclothes and was shouting for help from staff to get up. Staff, who were supporting another person nearby came to reassure the person calling for help; that they would soon be with them. However, staff then left the person lying partially exposed with their bedroom door wide open before staff returned to assist them to move.

We saw staff often offered people choices such as what to eat and drink and where they would like to sit. However, people were not always supported in relation to their occupational and lifestyle preferences concerned with how to spend their time. People's care plans did not always show their preferred daily living routines or their known choices and lifestyle preferences; to help fully inform staff about people's care.

People and relatives were not consistently involved in agreeing daily living, staffing and care arrangements at the service. Group or community meetings were not regularly held with people or relatives to help inform and agree this. Minutes of a sole meeting held with people's relatives in October 2017 showed they expressed disappointment in relation to this and the lack of related communication from the provider. We discussed our findings with the both the registered and regional manager who advised this was under review with a view to establishing regular meetings for service consultation with people and relatives. There was no information for people to know how access independent advocacy services if they needed someone to speak up on their behalf.

We received many positive comments from people and relatives, which included, "The staff treat people pretty good; They are kind and they talk to people about how they are caring for them; they approach us with a cheery word and I do think they are respectful; They always knock on the door before they come into my room." Another person told us, "The carers are kind, patient and polite; I have never seen anyone be abrupt, they are very understanding, considerate about people's privacy and treat everyone with the greatest respect." A relative said, "Staff treat people with dignity and respect; They seek permission, ask residents before they start to do something; if it is not the right time they may try and gently persuade, or they will just come back later." Two visiting health and social professionals spoke positively about the calm atmosphere in the home and the caring attitude of staff. One said, "They are caring staff; they know [person

receiving care] well; have a really good rapport and understand what's important to [person].'

We saw staff often ensured people's dignity, comfort, independence and choice. For example, by ensuring doors were closed when providing people's personal care. Staff took time to explain to people what they were going to do and checked people were happy before they provided care. We often saw staff check with people whether they were happy, comfortable and had personal items to hand such as walking frames for independent movement, before leaving them.

A regular service newsletter was provided, which people could access from the home reception area and also from the provider's website. This helped inform people what they could expect from the service and their care arrangements. Relatives, friends and external health and social care professionals said they were made to feel welcome at the home. People said staff regularly discussed their care with them and relatives felt they were kept individually informed about people's care. For example, following any changes or concerns in people's health condition. One person's relative said, "Yes, I am always kept informed and updated about [person's] care and any changes." Relatives also felt they were able to visit at any time to suit the person.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive timely, individualised care and support from staff. Three people and one relative told us about occasions when people either had to wait for assistance or had witnessed others waiting. One person said, "Staff are helpful and come as quickly as they can; they have been days when there could be more staff; but on the whole my needs are well catered for." Another person told us, "I walk with a walking frame and staff help me; If I need to go to the toilet I tell staff and they take me; sometimes I have to wait but not too long, but my friend sometimes has to wait too long and has been wet because of it." A relative we spoke with also confirmed this delay in assistance.

During our inspection we saw staff did not respond in a timely, consistent or appropriate manner when one person repeatedly requested their assistance. This caused some distress for the person and also other people nearby. We discussed our findings with both the registered and regional manager who agreed to investigate and take the action required to help prevent reoccurrence.

Staff told us about one person living with an acquired brain injury, who often had difficulty communicating their needs and could easily become distressed. Staff told us this sometimes occurred because the person often didn't understand what was happening around them or what they needed to do, For example, when the person needed support to complete their personal care tasks. Staff did not always know how to respond or describe a consistent approach to the person's care. This included supporting the person to accomplish their routine daily living tasks, such as washing and dressing in a way that was known to be helpful to them. Staff were not provided with a detailed care plan to follow for this to enable them to consistently promote the person's understanding and independence.

We did observe staff often responded to people in a timely, individualised manner and knew how to communicate with people in a way they understood. This included supporting people living with dementia and responding in a way that was helpful to them when needed. One staff member said, "I find it really rewarding working with people living with dementia; it's so important to try and put yourself in their shoes; to understand what it's like for them individually." We observed when one person living with dementia needed to go to the toilet but was unable to say; staff promptly recognised this from the person's non-verbal communication and responded in a timely and discreet manner to direct them. This was done in a way which helped to promote the person's autonomy and independence.

Some service information and environmental adaptations were provided to help promote people's inclusion, independence and orientation; but information was not always accessible to people in a format they could easily understand. We saw some use use of décor colour, picture and large print signs, to help support some peoples' orientation needs who were living with dementia. Memory boxes were also displayed outside some bedrooms, which contained personal objects or items that were meaningful to people to help them recognise their own rooms. Orientation boards in communal lounges provided accurate information to show people the day, date, season and weather. Following recent relative requests, written daily mealtime menus were also displayed. However, the provider had not fully considered the use of alternative information formats that may further assist people. For example, relevant pictures or symbols for people to

understand their care plans or food menus. We recommend the provider reviews their service information against nationally recognised accessible information standards for people who may benefit from this.

Written information was visibly displayed which showed a range of daily social, occupational and recreational activities provided for people. People and relatives felt people were not consistently offered varied occupational activities they may wish to engage in. One person said, "The days are long; we mostly watch television; There is a lady who does creative things sometimes; we play bingo or have an entertainer." Another person told us, "There are not a lot of activities going on; a lot television all day; I used to live in another home and there were a lot of things going on, but not here." Another person said, "There isn't something each day but we sometimes do baking or play games." Two relatives said, "There used to be a lot of activities here, but not much recently;" and "There are some activities, but they are not consistent." We did not observe any activities taking place for people to engage in during our inspection.

The provider did not regularly seek or act on feedback from people or relatives about their care, daily living and lifestyle arrangements; to ensure they were consistently provided in a way that met with people's needs and preferences. This meant the provider's arrangements for evaluating and improving the service was not effective.

The provider's complaints procedure for the service was visibly displayed. People and relatives knew how to make a complaint or raise a concern about the service if they needed. Some relatives had raised concerns about staffing levels and equipment repairs but had experienced long delays before these were acted on by the provider. Complaints and concerns received were logged and recorded as resolved but records did not always accurately show how this was achieved. This meant the provider's management oversight was not effective to ensure the timely handling and accurate recording of complaints received.

Requires Improvement

Is the service well-led?

Our findings

The provider's systems to check the quality and safety of people's care and related record keeping at the service were not effective. They did not always identify and ensure timely service improvements when required. This meant the provider did not consistently ensure people received safe, effective care; or that related records were accurately maintained and staffing arrangements were suitable and sufficient.

Before our inspection the local authority told us about safeguarding concerns they had raised with provider about people's care at the service. The provider's arrangements to check the quality and safety of people's care had not identified the concerns, which meant they were ineffective. We found some related management improvements were introduced for staff care communication and incident reporting, environmental and equipment safety and to help ensure sufficient staffing at the service. A management plan for care plan record keeping improvements to accurately inform people's care had commenced but was not yet completed or shown to be sustained.

Staff were not always supported to access the training they needed to provide people's care or to obtain qualifications to progress. Staff did not consistently understand people's care needs and were not provided with relevant care plan information to follow for people's positive behavioural support, related behaviour management and communication needs.

Complaints records were not accurately maintained. Details of complaints investigations, findings and any resulting care and service improvements were not always recorded; or whether the outcome was to the complainant's satisfaction.

The provider did not regularly seek and act on feedback from people or their relatives to help inform and improve the service when required. One person said, "I have never been asked my opinion or asked to complete a questionnaire or anything like that." Another person said, "No one has ever asked me what I think to the home." A relative told us, "I have never been asked what I think about the home."

The manager told us staff lead roles were recently identified at the service, to help champion areas of people's care and drive service improvement. They advised this included dignity, continence care, medicines, care planning and infection control staff leads. However, there were no related written role descriptions to clearly inform and support staff about their individual lead role responsibilities, including any related training requirements. This meant the provider's arrangements and resources to drive care improvement in this way were not clearly identified to enable this.

This showed people were not always protected from risks associated with ineffective monitoring and evaluation of the service and inconsistent record keeping. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People, relatives, staff and visiting professionals' views were variable about the management of service. One person said, "The manager has changed recently, I know who it is; I think the home is well managed now; I

don't have any concerns about that." Another said, "The manager has changed but I don't know who it is; I have never seen them." A relative told us, "The manager is approachable and very supportive recently; on the whole I have confidence in the manager and staff." Another relative said, "The problem lies with the provider; it starts at the top; they don't seem to support staff to do their job; the manager can only do so much."

The registered manager told us they had recently introduced regular management checks of people's health and nutritional status. Records showed this information helped to inform relevant care communications, such as staff handover information, care plan updates and information sharing with external health professionals and other care provider's when required. For example, following any changes in people's health needs or if they needed their care transferring to another care provider.

Relevant policies and procedures were in place for staff to follow to report significant incidents or concerns, such as in the event of an accident or serious incident, which staff now understood. This included a whistle blowing procedure if serious concerns about people's care need to be reported to relevant outside bodies to protect people from harm or abuse. Whistle blowing is formally known as making a disclosure in the public interest. This helped to promote an open and transparent culture

The provider sent the Care Quality Commission written notifications informing us of important events that had happened in the service when required. However, there was an unnecessary delay in sending one notification. We are liaising with the provider about their management arrangements for the service, following information we received after our inspection which tells us the registered manager no longer works at the service.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home and on their website.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from risks associated with ineffective monitoring and evaluation of the service and inconsistent record keeping. Regulation 17(1) & (2)(a)(b)(c)(e) & (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not fully protected against the risk of ineffective care because staff were not always trained or supported to perform their role and responsibilities for people's care. Regulation 18(2).