P Parmar

Dudley Court Care Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 and 23 May 2018 and was unannounced. Dudley Court Care Limited 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 22 people in one adapted building. At the time of our inspection there were 20 people living at Dudley Court Care Limited.

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 was on annual leave at the time of our inspection. The assistant manager assisted our inspection process. We met the nominated individual at the beginning of our visit on 17 May 2018 and spoke with them over the phone after the inspection.

People told us they felt safe. Staff showed understanding of how to recognise and report abuse although they had not all received safeguarding training. Staff were suitably recruited, and people's identified risks were not consistently safely managed by staff who knew them well. Systems and records were not robust to ensure consistently safe practice.
The inspection was prompted in part by notification of an incident following which a person using the service absconded. This incident was not reviewed and learned from to improve the safety of the service. We have made a recommendation about how incidents are reviewed and learned from.

People told us they received their medicines as needed however, records were not always accurately maintained to ensure people were always supported safely. We received mixed feedback around whether there were enough staff to meet people's needs, and systems were not in place to check staffing levels remained safe. Improvements were required to checks of the health, safety and cleanliness of the premises and to people's equipment.

Some people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, however this was not a consistent experience for all people. Policies and systems in the service did not support this practice. The provider had not met our previous recommendation to ensure people living with dementia would be supported as far as possible to make decisions.

People and relatives told us people were generally well supported. We saw examples of this and that some staff knew people well. Staff told us they felt supported. However, staff had not received training required for their roles to ensure people were always supported safely and in line with current good practice. Improvements were required around how some people were supported with their communication needs and in response to behaviours that may have challenged. The provider had not accessed current guidance around the design and décor of the home.

People were supported to eat and drink enough to maintain a balanced diet. People were supported to access healthcare support if they were unwell.

Feedback from people and relatives reflected positive experiences and we saw some caring interactions. However, some people's feedback suggested staff did not always respond appropriately, and engage well with people. We saw staff did not often communicate with people outside of care tasks. Systems did not ensure people were always supported to be involved in decisions and discussions about their care as far as possible.

People did not have consistently good access to activities although we received positive feedback about the group activities that took place. We saw good examples of how people's individual needs were met however this was not consistent for all. People and relatives told us they felt comfortable raising concerns with staff or management if they needed to. Systems were in place and under review so people could be supported as they wished at the end of their lives.

People and relatives were supported to engage with the service and told us they would recommend the service. Staff told us they felt supported. People's feedback was sought, however improvements had not been made to ensure this was gathered and analysed to effectively monitor and improve the quality of the service.

The service did not continuously learn and improve through reference to current good practice and requirements. The provider had not always met their regulatory requirements and areas of improvement brought to the provider's attention at our last inspection had not been fully addressed. Systems did not always ensure the safety of the service

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?

Requires Improvement

The service was not consistently safe.

People's risks were not always safely managed by staff who knew them well. Staff knew how to recognise and report abuse although they had not all received safeguarding training.

Most people felt there were enough staff to meet people's needs, however systems were not in place to check staffing levels remained safe. Staff had been suitably recruited.

Systems and records were not robust to ensure a consistently safe service, including health and safety checks and medicines management.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not all supported to have maximum choice and control of their lives; policies and systems in the service did not support this practice.

The provider had not accessed current guidance around the design and décor of the home.

Most people were generally well supported however staff had not received training required for their roles to help meet all people's needs. People's communication needs were not all met.

People were supported to eat and drink enough to maintain a balanced diet, and to access healthcare support if they were unwell.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always well engaged with and responded to by staff. Some staff did not often communicate with people outside of care tasks.

People were not always supported to be involved in decisions and discussions about their care as far as possible.

Feedback from people and relatives reflected positive experiences and we saw some caring interactions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have consistently good access to activities although we received positive feedback about the group activities that took place.

We identified good examples of how people's individual needs were met however this was not consistent for all. Systems were in place so people could be supported as they wished at the end of their lives.

People and relatives told us they felt comfortable raising concerns with staff or management if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service did not continuously learn and improve through reference to current good practice and requirements. Improvements identified at our last inspection had not been fully addressed.

Systems and processes did not always effectively monitor and ensure the quality and safety of the service.

People and relatives were supported to engage with the service and told us they would recommend the service. Staff told us they felt supported.

Dudley Court Care Limited

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.

The inspection was prompted in part by notification of an incident following which a person using the service absconded. This inspection examined those risks. The incident was brought to the attention of the police and the local authority.

The inspection took place on 17 and 23 May 2018 and was unannounced. The inspection was conducted by an 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 areas of expertise included the care of older people and dementia care.

As part of our inspection planning, we sought information and feedback from commissioners of the service and the local authority safeguarding team. A commissioning officer also visited the service during our inspection on 17 May 2018. We 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 this and other information we held about the service to help inform our inspection planning. This included notifications submitted by the provider. A notification is information about important events which the provider is required to send us by law.

During our inspection, we observed how people were supported including use of 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 also spoke with six people, five relatives, three staff, the assistant manager and the nominated individual. We looked at records relating to the quality and safety of the service including records relating to four people's care and two staff recruitment files. After our inspection, we spoke over the phone with a district nurse team, a speech and language therapy team and commissioners of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2016, we had rated this key question 'Good'. At this inspection, we found systems were not always effective to ensure the safety of the service, including in relation to learning from incidents, staffing arrangements and medicines management. We have rated this key question, 'Requires improvement'.

This inspection was prompted in part by an incident whereby a person had absconded, leaving the home through a lounge window. Staff had not noticed the person leaving and other residents told staff the person had left via the window. The provider had ensured relevant partner agencies were informed of this incident and safeguarding concerns, however the incident had not prompted an internal review of people's safety at the home. The assistant manager told us they had been present during the incident and therefore did not see that it needed to be investigated, and we found an incident form had not been completed. During our inspection six days later, there were still risk factors which had not been addressed by the provider. For example, other windows had not been checked to ensure they were fitted securely, and staffing arrangements had not been reviewed as possible ways to avoid similar incidents happening in future. It had been agreed that staff would regularly check in on the person after the incident, however we saw a staff member forgot about doing this and did not know where the person was. All possible action had not been taken to keep people safe.

We recommend that the service takes steps to ensure all safety incidents are recorded, reviewed and learned from, and measures implemented to reduce risks to the safety of people living at the home.

Most people we spoke with told us there were enough staff to support them and to respond promptly when they asked for help. For example, one person told us staff responded quickly to call buzzers used to get their attention, however another person commented that staff were rushed at times. We saw staff were often visible but not always available to spend time with people and respond to their needs. For example, some people spent time in lounge areas with little interaction. Staff were not always present to reassure some people when they were upset or to engage them in conversations and activities. We received mixed feedback about this. There was no formal system to regularly check and ensure staffing levels met people's needs. Systems were not in place to ensure staffing arrangements were always suitable and that incidents were learned from to help ensure people's safety.

People told us they received their medicines as needed, however systems did not ensure people always received safe support. Staff had not received guidance through competency assessments which is in line with current good guidelines to ensure their practice was appropriate. Some medicines records we sampled were not completed accurately to show how people should be supported safely. For example, people's use of 'as and when' medicines were not monitored as planned, and records did not specify how one person's pain relief patches should be applied. People did not have concerns about this aspect of their care. One person told us, "[My medicine] is given to me by the staff and it's done correctly." We saw another person was given advice and reassurance about their medicines from a staff member. Improvements were required to ensure people received consistently safe support with their medicines. After our inspection, the provider

told us that refresher training had been provided.

Improvements were required to ensure all people's equipment was well maintained and ready for their use. Equipment had been serviced and we saw people were safely supported when using this. However, this was not consistent practice and routine checks were not in place at the home to ensure equipment remained safe. For example, we saw a staff member sat on a pressure relief cushion intended for a person at risk of developing sore skin. The cushion was dirty with old dried spillages and torn in one corner. The staff member could not tell us who the cushion belonged to, and there were no labels or ways on other cushions to identify this. This did not help provide consistently safe support to reduce some people's risks of developing sore skin.

People's known risks were not always reduced or managed effectively. We were assured that people's risks were generally well managed, for example, staff were aware of people's changing eating habits and who was at risk of losing weight. Some people had been supported to take supplements to help them reach healthier weights previously. In another example, staff knew who was at higher risk of developing sore skin and told us how they supported them safely to help reduce this risk. However, for both of those risks, and other identified risks relating to people's needs, systems and records did not always support and demonstrate consistently safe practice. For example, we brought it to the assistant manager's attention that some people had not been weighed more often as had been planned due to risks that they had lost too much weight. In another example, district nurses told us practice around reducing the risk of sore skin was improving, however as we found, they told us records relating to this support were not detailed enough to help always quickly identify and monitor risks effectively.

People told us they felt safe. One person told us, "I feel safe here. I've not seen anything that worries me." Staff we spoke with understood how to recognise and report abuse although they had not all received safeguarding training. The assistant manager confirmed training plans would be reviewed. Staff often showed a good awareness of people's risks and changing needs and how to help keep people safe. A relative told us they felt people were safe and commented, "Staff know [person] well." We saw steps had been taken to reduce the spread of germs when some people were ill with the flu, and staff wore Personal Protective Equipment (PPE) and hand sanitizer was available. A relative told us, "I went to the home once and had picked up a bug. I was asked to leave, I thought that was very good," because it was in order to help keep people well.

We checked two staff files and found that they had been suitably recruited. Records showed character reference checks, and checks through the Disclosure and Barring Service (DBS) were completed before staff started in their roles. This helped reduce the risk of people being supported by staff who were unsuitable. The provider had not addressed our last inspection finding however, to ensure recruitment decisions were always recorded, and we found some information relating to staff recruitment were not stored as required.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2016, we rated this key question 'Good'. At our last inspection, we made a recommendation for the provider to access information about current good practice about supporting people living with dementia to make decisions. This had not been done. We also found staff had not received the training required for their roles, and the provider had not referred to current guidance in relation to the design and décor of the home. We have rated this key question, 'Requires improvement'.

Some people living with dementia were not able to express their needs verbally. Some staff gave examples of how they supported people to make decisions; however, this was not consistent practice by all staff. For example, we saw one person was not supported to understand and respond before a staff member helped them to eat a meal. Resources such as visual cues were not used or considered as possible ways to help some people understand and make decisions about their care. A staff member told us they thought this type of support could help another person express their needs and wishes, but we saw they were not in use and the person struggled to express their wishes to staff verbally. The provider had not followed our previous recommendation to access current good practice guidelines to support all people to understand and make decisions as far as possible.
The needs of some people who became distressed and showed behaviours that may have challenged were not always effectively met. Relatives gave positive feedback about this, and some staff outlined effective ways they supported people. However, this was not consistent practice and we saw some staff did not respond to, and try to reassure those people. A staff member told us, "Some staff don't know how to deal with [one person's] problems and could do with a bit more training about behaviours that may challenge." Care plans were not developed to help all staff understand people's needs and behaviours. One person's care plan gave generic guidance and did not clearly outline the person's needs and how to effectively monitor and meet these.

One person commented, "I think that the staff are well trained." Most staff showed a good awareness of people's needs and how these should be met. However, staff had not received training identified as mandatory for their roles including about dementia care, mental health, infection control, and people's nutrition and hydration support needs. Only some staff had completed training about fire safety, safeguarding, safe moving and handling and person-centred care. The provider had checked what training staff had received in previous roles, but not provided their own training to ensure staff were aware of current good practice and how to safely meet the needs of people living at the home. Although the cook was aware of people's dietary needs, they had not received recent training to help maintain their knowledge. Systems did not ensure staff were competent and equipped with the necessary skills and training to always support people effectively.

Our discussions with the assistant manager and our observations found the provider had not referred to current good practice to develop the design and décor of the home around the needs of the many people at the home living with dementia. For example, suitable signage and doors painted in distinguishable colours had not been considered or trialled, as possible ways to help navigate people to their rooms and other parts of the home. A relative commented the home was, "A little bit tired in places," referring to visible marks

where paint had come off a wall as an example and our observations supported this.
Some people told us they liked their rooms and had some photographs on display. One person commented, "There is a lovely patio and nice garden." A relative told us, "It's a homely home in terms of how it is decorated, it's how [person] wants it, and they have a view of the garden. They've put pictures on the wall as [person] wanted." The assistant manager told us non-slip flooring had been fitted to help reduce falls and that people had picked a lounge carpet, although there was no evidence beyond this that the provider had considered current good practice requirements in this area.

Our inspection also found positive examples of how some people's needs were met. People and relatives told us people were generally well supported. One person told us, "I definitely get the support that I need." Staff regularly shared information for example, on their whereabouts and if a person needed support. Staff were aware of two people's recent use of new equipment and how to support them safely. A staff member told us, "Staff were shown as soon as they were on shift how to use [a new hoist]." We saw some staff took good care to support people. For example, one person was encouraged to move safely at their own pace with a walking frame. Another person was encouraged to sit back in their chair, so they wouldn't fall. Some staff gave clear accounts of people's needs, how people expressed these and their individual risks. Supervisions and staff meetings were held, and staff told us they felt supported. A staff member described their induction to us: "The induction included looking through people's care plans and shadowing. It was detailed and managers treat people like their family." The staff member told us they were encouraged to go to the managers if they were unsure, and the registered manager did random knowledge checks with staff about people's needs.

People spoke positively about meals and told us they were given food and drinks of their preferences. One person told us, "The food is good. You have what you ask for." Another person told us, "It's very good food. You have breakfast then you're looking forward to the next meal and the next." People's dietary requirements and changing needs were known to staff and monitored. Some people had returned to a healthier weight after support such as supplements. People were supported to eat and drink enough to maintain a balanced diet.
People were supported to access healthcare support. One person told us, "If I'm ill, they [staff] get the doctor for me." Another person told us, "If necessary I see the GP. I also see the chiropodist. The optician came recently and I also had my hearing checked." Relatives told us they were kept informed as appropriate about changes to people's health.

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.

With continued input from a doctor and the support of staff, one person's wishes not to have a softer diet as recommended were met. Different options were trialled with the person and their relative told us the person was, "Over the moon," with a recent meal they could have. This helped promote the person's safety whilst respecting their own decisions about their care. Another relative described how staff had prioritised the person's choices over the views of others as appropriate. The relative told us, "Staff said, it's [person's] choice," about an issue they had raised. Although people's expressed wishes were respected and they were supported to make their own decisions, this was not a consistent experience for all people. Care planning had not explored how and when other people, for example those who could not express their views verbally, could be supported to make their own decisions as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff showed understanding of the MCA and who had DoLS authorisations in place and why. The assistant manager had a tracker in place to establish whose applications had been authorised and their expiry date. One person did not have a DoLS authorisation in place and told us, "I don't go out much, I can go out as I please but it is good to have someone with you." There were positive examples of how some people's choices, and their liberty was promoted, however not everyone was supported at the home in line with the principles of the MCA.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in September 2016, we rated this key question 'Good'. At this inspection, we found the service was not consistently caring and people were not often well engaged with and involved in their care as far as possible. We have rated this key question, 'Requires improvement'.

People and relatives told us staff were kind. We saw examples of this and positive, caring approaches from staff. However this was not consistent across the staff group and some feedback we received suggested staff did not always respond appropriately to people. One person told us although staff were kind, they found, "I might rub them up the wrong way sometimes… They get a bit cheesed off, we get on top of them." Another person told us, "One of the staff loses her patience with [another person] sometimes." This did not demonstrate a consistently caring and compassionate response to people from some staff. We raised the feedback with the assistant manager who told us they were not aware of any such issues at the home. We saw people had limited interaction from staff throughout the day and outside of care tasks. One person told us, "The staff are kind but they are busy." We saw some staff greeted people as they came in, and addressed people kindly. However, when some staff were present in communal areas, they often had their heads down, completing paperwork and did not speak to people or spend time with them. Staff often greeted the inspection team but did not routinely do this with people living at the home. People did not experience a consistently caring service.

Systems did not ensure people were always supported to express their views, and be actively involved in making decisions about their care as far as possible. One person told us, "No one talks to me about my care." Another person told us, "I've not spoken to anyone about my care. I've not been involved with that at all." One person's records we sampled reflected their input in care planning but we did not see this in other records we sampled. Some staff gave good examples of how they supported people who could not express their needs verbally, and how they involved them in their care and decisions about this. For example, one staff member told us they checked in and chatted to people who were cared for in bed and were mindful not to isolate them. We observed however that one person was not greeted or addressed appropriately by another staff member who came into their room to help them to eat. The staff member moved the person's bed, so they could get closer to the person and help them to eat, but did not talk to or tell the person this before doing so. When the person made some non-verbal sounds, the staff member then told them what they were having for lunch and asked them, "Are you listening." The person was not able to reply. This did not demonstrate an understanding of the person's needs or compassionately involve the person in their care.

We identified some practices and use of language which did not reflect and promote a consistently caring culture. Staff had not received planned training in dignity and respect and we heard some use of task-based language relating to people's support such as 'feeders' and one person was referred to as, 'Whatshername'. Some people's walking frames were often stored away from them, which meant they would not be able to safely stand and move independently as they wished.

Our inspection also found positive examples of how people were supported. We saw some positive

conversations and good rapport between people and staff. One staff member told us the home was like, "A second home," to them. We saw they stroked one person's arm with affection and encouraged the person saying, "Have your sandwich, that's it, well done." People told us their privacy was respected. One person told us, "The staff always knock on my door before they come into my room. They always explain what they are going to do." People's choice around spending time in their room was respected. A staff member described how they promoted one person's independence by walking alongside them, commenting, "It's a short walk to the toilet, I stand by their side and still support them."

People we spoke with told us staff were kind. One person told us, "They make nice cakes for your birthday. Mine was lovely." Relatives told us staff were kind and the home had received compliments reflecting this. We saw some individual staff were caring and relatives told us some of their experiences of this. They showed a clear caring approach in their roles and other feedback we received reflected this. One person told us, "The staff look after me and talk to me. They can tell when I'm upset and come to talk to me." Another person commented, "[Staff member] always comes for a cuddle," and that they often joked with them. A relative told us, "Staff are so good with [person], they're so friendly and down to earth. When staff go in [to person], their face brightens up, she is happy to see them."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2016, we rated this key question 'Good'. At this inspection, we found people did not all have good access to activities and care planning had not helped address all people's needs. We have rated this key question, 'Requires improvement'.

Some people and relatives told us there were not enough activities of interest to people. One person told us, "I would like to do more activities." Some people and relatives spoke positively about the activities on offer. We saw people often had little to do and were not engaged throughout the day. Some people responded well to playing board games with staff, and a planned activity had been cancelled at short notice.
A senior carer told us, "We have a lot of activities, [external activity] people come in, dominoes, bingo, cards, [people] all get excited and respond well." We saw that people responded positively to the activities that were on offer. One person told us, "I like to exercise to music, the man who does that is very good." Another person told us, "I enjoy the activities that they do here, especially the quizzes." Some people read books or a newspaper. A staff member helped one person choose between two books to read, one of which the staff member had brought in and was able to describe to the person. We saw they had a good rapport and the person was supported to their room as they wished to read there. Some people enjoyed individual activities and responded well to group activities, however this was not a consistent experience and activities were not always linked to individual people's preferences and interests.

We were told people's care plans were put together to include what they enjoy doing, new skills people wanted to develop and their life histories. We saw people's care plans were regularly updated and how people's needs and risks were considered. However, some people's communication needs were not met as far as possible and care planning had not been developed around these and some people's behaviours. Some people's communication needs were known to staff, who outlined how they understood the person and helped them make choices. A senior carer gave examples of how they understood people who did not express their needs and wishes verbally, for example understanding their facial expressions and gestures. They described with affection how one person closed their eyes and pretended to sleep when they no longer wanted to talk. Some steps had been taken to help meet people's needs, for example interpreters had been requested for two people whose first language was not English. This had not been effective for those people however other methods such as visual cues had not been tried.

Systems were in place and under review so people could be supported as they wished at the end of their lives. There was evidence that some people's needs at end of life had been reviewed and monitored with healthcare professionals. One person at end of life care had relevant documentation in place reflecting their wishes which had been completed with the support of their relatives, staff and the doctor. The assistant manager described some discussions held with the person and their family and that the person's wishes to remain at the home were being met. Pain relief medication had been supplied for another person at end of life. A staff member told us, "Residents are classed as family. The registered manager and staff are upset if people pass away." Other people had not yet discussed this aspect of their care. One person told us, "No one has talked to me about what would happen if I became very ill. If I did become very ill I would want to stay here, I don't want to be taken to a hospital." The assistant manager told us they were reviewing this, and

looking to arrange end of life training to develop staff understanding in this area.

People were supported to have their choices and wishes met, for example, people could get up when they wanted. A night staff member told us, "We leave people if they want to [stay in bed], we don't have the right to force them." We saw staff respected people's expressed wishes about their care and a monthly religious service had been arranged at the home which some people chose to attend. The assistant manager and staff also gave us examples of how they recognised some people's individual identities and talked to people about their interests and backgrounds. For example, one staff member told us they spoke about certain foods they knew one person liked, which the person responded to well. The staff member described how another person spoke to them about their religious beliefs, and told us they had needed to build up trust with the person before they did so. This showed they respected the person's boundaries and how they wanted to be supported with their religious needs. However, we did not observe this was a consistent approach by all staff in response to some people's needs, for example where some people became distressed, and people had not been involved in their care planning as far as possible to ensure their needs and preferences could be understood and met. Staff had also not all received training centred around people's individual needs, such as equality and diversity, and person-centred care training to help inform this practice. We found positive examples of how some people's individual needs were met, however systems did not ensure this was consistent practice through person-centred care planning and guidance for staff.

People and relatives told us they felt comfortable raising concerns with staff or management if they needed to. One person told us, "I have no complaints, if I did I would tell them." A relative told us, "I could definitely complain. I get on well with the managers and I could speak to them." People were invited to share any concerns during 'residents' meetings' and relatives told us feedback would be used to help improve the service.
There was no system to clearly record and monitor complaints, and ensure people had accessible information about how to complain if they needed to. The assistant manager told us they couldn't recall that any complaints had been received. The assistant manager told us they would review this, as well as introduce formal ways to monitor 'grumbles' and other feedback to help effectively monitor and improve the quality of care.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2016, we rated this key question 'Requires improvement' because systems to monitor the quality and safety of the service were not effective. At this inspection we found improvements were still required. We have rated this key question, 'Requires improvement' for a second time.

Systems did not always promote people's safety as far as possible. Water temperature checks had identified high temperatures but had not prompted action to reduce the risk of people being exposed to unsafe water temperatures. After our last inspection, we contacted the fire service due to concerns in this area. We found improvements were still required. Some staff had not received fire safety training and although personal evacuation emergency plans had been completed for each person, this information was not readily available for use in the event of a fire. A recent incident which had in part prompted our inspection, had not been investigated or reviewed for ways to reduce future reoccurrences.

We saw there were some systems and processes in place for monitoring the quality and safety of service, however they were not always robust. A "Regulation 17" audit had been introduced since our last inspection, and included discussions with a small sample of people and staff to see if they were okay. Incidents such as falls had been monitored well for each individual, including the timing and nature of falls. However, systems had not ensured records were always robust to effectively monitor all identified risks such as behaviours, sore skin and weight loss. The assistant manager told us another audit would be introduced so that training gaps would be identified and actioned in a timelier way in future. We found the provider had failed to ensure staff all had the skills and knowledge for their roles, and the majority of mandatory training had not been provided. The assistant manager told us they observed staff regularly but there was no record of this.

The service did not continuously learn and improve through reference to current good practice and requirements. Infection control and cleaning audits devised by the management team were not based around current good practice. People told us the home, and their rooms, were clean, however cleaning schedules and audits did not ensure cleanliness and good infection control practices within the home and we found some improvements were required in this area. We showed the assistant manager guidelines about how to develop the design and décor around people's needs. Some improvements were required in this area and we saw no evidence the provider had referred to such guidance. The assistant manager asked us in response, whether making reference to such guidance was now a requirement. This did not demonstrate a vision or strategy to continuously learn and deliver empowering, high-quality care for people.

Areas of improvement brought to the provider's attention at our last inspection had not been fully addressed. We had made a recommendation for the provider to access information about current good practice to support people living with dementia to make decisions. This has not been done and care plans did not show how people could be supported to make their own choices as far as possible. As found at our last inspection, the provider had not taken timely action to ensure their ratings were conspicuously displayed as required. This meant people did not have current information about the performance of the service. This was addressed shortly after our inspection.

At our last inspection, people's feedback was not effectively sought and analysed to drive improvements to the service. At this inspection, we found this had not been fully addressed. Feedback questionnaires had still not been made accessible to some people and still needed to be rephrased to help some person understand and give their feedback. This did not give people the opportunity to complete their feedback independently and with anonymity if they wished.
Although raised at our last inspection, people's feedback was still not analysed overall for possible trends and patterns affecting the quality of the service as a whole. Most feedback we sampled from July 2017 was positive, however some people had raised staffing levels as a possible area of improvement and another person had commented that the home needed a bit of decorating. The responses to those individuals were not robust and had not led to improvement plans and outcomes. For example, the analysis of one person's feedback which included reference to staffing levels, had an outcome of, 'Excellent review' with the plan, 'to continue with the high quality [care] being given,' with no action points. People's feedback had not been used to effectively monitor and drive improvements to the quality of the service, and our inspection found improvements were still required in areas they had raised.

Failure to establish and operate systems and processes to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Commission had been notified as required about specific events and incidents as required, however they had not submitted notifications to confirm the outcome of DoLS applications as required. This is in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are deciding our regulatory response to this and will issue a supplementary report once this decision is finalised.

People, relatives and staff were supported to engage with the service and spoke positively about the registered manager. One person told us, "The manager has her eye on everything the whole time. She's wonderful you can always go to her if you have a problem." Another person told us, "If I ever want to talk to someone, she's there, she's good and helped me with a few things." Meetings were held with people, staff and relatives who generally reflected a positive experience of the service. A relative told us they had regular contact with the service to hear how one person was. Another relative told us, "They really take what we think into consideration."

All people told us they had no suggestions for improvements for the home and that they would recommend the service. One person told us, "It's very nice living here I like it. I would recommend this home to anyone." Another person commented, "If you were asking me about living here I would tell you yes, come and live here it's nice." A relative told us, "It's a family run sort of place. It's the kind of place I'd like [to stay]." The service had helped achieve good outcomes for people, for example responding to their risks with input from healthcare professionals to promote their health.

Staff told us they felt supported. A staff member told us, "I have gone to the [registered manager] with personal problems and work things, if I'm concerned about a person, staff member. The manager gives me full support. Everyone chats and is friendly, and asks for help about people's needs." Another staff member told us the registered manager dealt effectively with any issues between staff. The provider had involved and supported staff through a recent investigation. A staff member told us, "We all learned from it, we all do what we're supposed to." The provider had checked whether staff would feel able to approach them with concerns. Staff meetings were held where people's changing needs and preferences were discussed, with reminders for staff about their roles.

Commissioners visited the service on 17 May 2018 while we were present at the service and told us they had

issued an action plan to provider setting out a number of improvements required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate systems and processes to assess, monitor and improve the quality and safety of the service.