T.L. Care Limited

Ingleby Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 October and 15 November 2016. Both days of inspection were unannounced which meant the registered provider and staff did not know that we would be attending.

We previously inspected the service on 18 and 22 December 2014 and found that the service was not meeting all of the regulations which we inspected. We found the service was not meeting the regulations for consent to care and treatment and good governance. This was because the service did not have suitable arrangements in place for obtaining consent. The service had not been following the principals of the Mental Capacity Act 2005 and this had not been picked up by the quality assurance measures in place at the time. There were also gaps in the quality assurance systems in place at the service. We noted that audits had regularly highlighted the same areas for improvement and actions plans had not been put in place following these audits. The registered manager was not given feedback following these audits which meant they had been unable to make the changes needed.

After inspection, the registered provider supplied an action plan to show us the action they had planned to take to improve the quality of the service.

Ingleby care home is registered to provide accommodation for people who require personal care, treatment of disease, disorder and injury and diagnostics and screening for up to 56 older people including people living with a Dementia. The service is located in a residential area within its own grounds and has on-site parking. The service is located close to local amenities. At the time of inspection there were 44 people using the service

The registered manager had been registered with the Commission since 21 January 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, we could see the registered provider had made some improvements to their quality assurance processes. Appropriate procedures were in place to obtain consent. This meant they were following the principals of the Mental Capacity Act 2005.

At this inspection, we found improvements were needed to the quality and accuracy of record keeping at the service.

Some risk assessments reviewed were inaccurate because scores had not been calculated correctly. We could see that there had been no negative impact on people because of these inaccuracies in the records. There were also gaps in the information contained in care plans.

Topical cream records had not always been completed. This meant it was not clear if people were receiving their topical creams as prescribed. We also noted gaps in nutrition and hydration monitoring records. The registered manager told us that although there were gaps in these records, they were satisfied that people were receiving an adequate nutrition and hydration intake.

Staff showed they understood the procedures which they needed to follow if they suspected someone was at risk of abuse. Staff were able to discuss the types of abuse which people could be at risk from and how they could help to minimise these risks. All staff spoken with told us they would not hesitate to whistle blow (tell someone) if they needed to.

Risk assessments were in place for people's specific needs and for the day to day running of the service. Some risk assessments for people contained detailed information and had been regularly reviewed.

Health and safety certificates for the premises were up to date and showed that the service was safe for people and staff. Fire safety system checks had also been completed and staff had participated in regular fire drills.

All staff had a Disclosure and Barring Services check in place. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups.

People, their relatives and staff told us there were enough staff on duty throughout the day and night to care for them safely. We could see staffing levels were regularly monitored.

People received their prescribed medicines when they needed them. From our observations, we could see that people were supported to take medicines and people were given the time they needed to do so.

Staff told us they were supported during their induction period and records confirmed this. We saw staff shadowed more experienced staff whilst they became familiar with people using the service and the requirements of their role.

All staff were supported to carry out their roles effectively. Staff received regular supervision, appraisal and training. These also included observations of practice. When we reviewed supervision records, we noted gaps in the recording of information contained within them.

People told us staff sought their consent before any care and support was given.

Staff had increased their knowledge and understanding of the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLS). Staff were confident in these areas when we spoke with them and felt able to seek further support from the registered manager if they needed to. We noted that not all MCA assessments and best interests' decisions were decision specific. The operations manager told us they were already aware of this and support was in place to address this.

Staff understood the action they needed to follow to ensure people received adequate nutrition and hydration. We could see that staff completed risk assessments and updated care plans when people became at risk of malnutrition or dehydration and worked alongside health professionals.

We were concerned that there was only one readily available choice at mealtimes. If people wanted something else to eat, they needed to wait for the meal to be prepared. However people spoke positively about the food provided to them.

People told us they had access to health professionals when they needed them. We saw evidence of this during inspection from our discussions with people and staff, from our observation of visiting professionals and from the care records we looked at.

People and their relatives spoke positively about the care and support they received from staff. People told us they enjoyed living at the service and felt well cared for.

Not everyone we spoke with was sure if they had been involved in developing and reviewing their care plans. Records did not always show if this had been the case, however people told us staff always asked their permission before care and support was carried out.

People told us they privacy and dignity was maintained at all times. During inspection we observed good practices from staff.

Care plans were in place for people and had been reviewed. We noted that some care plans contained detailed person-centred information.

People told us they enjoyed the variety of activities provided at the service. From speaking with people we could see they also went out into the community to local shops and participated in community events. We could see that activities at the service had a positive impact upon people's lives.

People and their relatives told us they knew how to make a complaint and felt confident that action would be taken. We could see a small number of complaints had been made and records detailed the action taken to resolve the complaint and included the outcome of the complaint.

Staff told us they were happy working at the service; they were positive about one another and communicated well. All staff told us they were supported by the registered manager. All staff told us they could approach them if they needed to.

The registered manager had good links with the local community and people attended events within the community. The local community were also invited into the service for events. During inspection, the service was visited by local school who participated in a Halloween party.

The registered manager had made some improvements to the procedures in place for monitoring the quality of the service. Action plans were in place when audits had been carried out. These were actioned and checked by the regional manager during their monitoring visit. The regional manager also carried out their own audit of the service.

The registered manager regularly reviewed all safeguarding alerts and accidents and incidents. This meant patterns and trends could be identified and action taken to minimise the risk of reoccurrence and harm to people.

Surveys had been carried out and had been aimed at people and their relatives, staff and health professionals. Positive themes had been identified and action plans created when improvements were required.

Staff and people told us they were kept up to date with any changes or events occurring at the service and minutes were available if they had not been able to attend any meetings. We could also see that people had access to regular newsletters and had been invited to participate in the latest survey.

The registered manager had good links with the local community. People actively attended community events.

We could see that staff understood the requirements of their role and worked under the guidance of the registered manager to ensure people received safe care and support. We could see the staff team worked well together and communicated well.

Notifications, which are legally required and contain information about incidents in the service, had been submitted to the Commission when required to do so.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was not always safe.

People told us they felt safe living at the service and there was enough staff on duty to provide care and support to them.

Risk assessments were in place, however they had not always been completed correctly which meant they were inaccurate.

People received their prescribed medicines on time. 'As and when required' medicine protocols lacked person-centred information and topical cream records had not always been completed.

Is the service effective?

Good

The service was not always effective.

The service had made improvements to the way they worked in line with the fundamental principles of the Mental Capacity Act 2005. However, we found best interest decisions were not always specific.

Nutritional risk assessments did not always contain accurate information. People had received regular nutrition and hydration, however records of these had not been kept up to date.

Staff received appropriate support to carry out their roles. This included regular supervision, appraisal and training.

Is the service caring?

Good

The service was caring.

People told us they enjoyed living at the service and felt cared for by staff.

People told us staff involved them in their care by encouraging them to do what they could and by asking their consent before any care and support was carried out.

People told us their privacy and dignity was always maintained.

People were left unattended at times and there were missed opportunities to provide meaningful interaction with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records did not always have the information needed to provide person-centred care and support. Some care records contained inaccurate information.

A variety of activities were available at the service and some people participated in activities in the community. People spoke positively about the activities provided at the service.

People told us they would make a complaint if they needed to and felt confident that they would be listened to and the registered manager would take action to investigate their complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff told us they enjoyed working at the service and felt supported by the registered manager. People, staff and relatives spoke highly about the registered manager.

The registered provider took action to appropriately monitor the quality of the service which included audits, observations and feedback. Action plans had been produced when needed. However, they had not identified our concerns with record keeping and scoring risk assessments.

People, their relatives and staff were kept up to date with any changes occurring at the service and with upcoming events. The registered provider also took action to seek regular feedback.

Ingleby Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

One adult social care inspector and two experts by experience carried out an unannounced inspection on 31 October and one adult social care inspector carried out an unannounced inspection on 15 November 2016. This meant the registered provider and staff did not know we would be attending on either days of the inspection. The two experts by experience had experience of supporting older people, including people living with Dementia.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service and they told us they did not have any concerns about this service.

The registered provided completed a provider information return (PIR) when we asked them to. 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.

During this inspection, we spoke with 17 people who used the service and four relatives. We also spoke with the operations manager, registered manager, one senior care staff, an activities coordinator, three care staff, one administrator and one domestic member of staff over the two days of inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed five people's care records and the supplementary records of a further six people. These included medicine administration records, topical cream records, food and fluid balance records and daily

records. We reviewed four staff recruitment records and three staff induction records; we looked at the supervision and training summary records for all staff and six supervision and appraisal records in detail. We also reviewed records relating to the day to day running of the service which included meeting minutes, quality assurance records and the registered providers' policies.

Good

Is the service safe?

Our findings

Everyone we spoke with during inspection told us they felt safe living at the service. People told us staff were never far away from them and respond promptly to them if they pressed the buzzer or called out. One person told us, "I feel very safe here, even at night." One visitor felt their relative was safe because of the locks on the main door and fire alarm tests carried out every week. They could also recall having to gather in a designated meeting point as part of a fire drill.

Safeguarding records were in place and detailed the reason for the alert, the investigation and the action taken by the service to reduce any risk of harm to people. Staff training in safeguarding procedures was up to date and staff displayed good knowledge about the procedures which they needed to follow if they suspected abuse could be taking place. All staff told us they would not hesitate to whistle blow (tell someone) if people or staff were at risk of harm or abuse. One staff member told us, "I would always report [potential abuse] to the deputy manager or [registered] manager and they would put a safeguarding alert in."

Risk assessments were in place for falls, pressure area care and nutrition. When people's risks had changed, we found staff had completed risk assessments, had made appropriate referrals to district nurses, falls team and dieticians. They also ensured any specialist equipment, such as sensor mats for people at risk of falls had been put in place.

Health and safety checks had been carried out at the service and up to date maintenance certificates were in place. This meant the service was safe for people and staff to use. Regular water temperature checks had been carried out and records showed all were within safe temperature limits.

Regular checks of fire safety measures and equipment had taken place. Staff training in fire safety was up to date and staff had been involved in regular fire drills. This showed staff were competent to act appropriately in the event of a fire to ensure the safety of people who used the service. People told us that testing of the fire alarms took place every week and fire doors automatically closed which meant fire systems protected people. Some people told us they had participated in fire drills.

Accidents and incidents had been recorded and care plans updated. Records showed the action taken to minimise the risk of reoccurrence.

Each person had a 'Personal Emergency Evacuation Plan,' (PEEP) which contained good detail about people's individual needs. This included information about people's mobility, any equipment needed and any specific health conditions.

There were enough staff on duty to provide safe care and support to people. Staff told us that there was generally enough staff to meet people's needs. When we spoke with people, we received mixed reviews about staffing. One person told us, "They [staff] are run off their feet." Another person told us, "There are not enough staff." A third person told us, "There are not enough staff. They are always busy." People also told us

staff promptly answered their call bells, however there could be a delay when staff were busy. People told us this did not cause them concern and they received care and support when they needed it. A dependency tool to determine staffing levels and staff rotas were in place and showed there were sufficient staff on duty. The registered manager and regional manager both monitored staffing levels and told us staffing would be increased if people's needs changed.

The service had good systems in place for the management of medicines. Staff ensured people had adequate supplies of their prescribed medicines which arrived in a timely manner. Staff told us that all medicines were checked once they arrived at the service and they dealt with any discrepancies if they arose. Medicine administration records (MARs) had been fully completed and following our checks of people's medicines, we could see people had received their medicines as prescribed.

Some people were prescribed eye drops. These had a short shelf life; we noted that bottles had a date of opening on them, which meant staff knew when they needed to be disposed of.

Controlled drugs were in use at the service. These are specific classified drugs that must be managed in a particular way to ensure they are safely handled and administered and therefore less liable to misuse. We noted that people received these medicines when they needed them and two staff signatures were in place. Staff told us that these medicines were stock checked during each shift.

Some people required medicines on an 'As and when' (PRN) basis. Protocols were in place for people; however we noted they did not always contain the information needed. PRN protocols for two people did not provide information to show how staff might identify when people needed PRN medicines. We noted that these people had Deprivation of Liberty Safeguards (DoLS) in place which meant they could not make a decision about medicines. We asked staff why these people might need these medicines and how they would know they needed these medicines. Staff were able to tell us, however the records did not reflect this. We discussed this during feedback with the registered manager and they told us action would be taken to update these records. Staff told us that one person was refusing to take one of their PRN medicines and had contacted the person's GP to review this.

Staff training in medicines was up to date and competency checks had been carried out to make sure staff remained safe to dispense medicines.

Good

Is the service effective?

Our findings

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection, we found the service was not meeting the requirements for Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had been completing Deprivation of Liberty Safeguards (DoLS) for people, however they had not carried out Mental Capacity Act (MCA) assessments when they suspected people might not have the capacity to make their own decisions. Some people's care records also stated they did not have capacity but there were no MCA assessment in place to support this. This goes against the fundamental principles of the Mental Capacity Act 2005 which assumes capacity until appropriate assessment proves otherwise.

At this inspection, we could see the registered provider had taken action. Mental Capacity Act assessments had been carried out and DoLS applications made when needed. Although MCA assessments had been carried out, they were not always decision specific. For example, a MCA assessment for one person included use of a key pad, ability to leave the building on their own, medicines, personal care, diet and sensor mats. Each of these key areas required a separate MCA assessment because people's ability to make decisions in these key areas could be different. We also noted that best interest's decisions were not always person specific, for the same person one decision had been made for residing in a safe place, receiving a nutritional diet and twenty four hour monitoring. This person also had a lap belt in place; however no best interest's decision had been carried out for this.

It was clear that improvements had been made since the last inspection, but further improvement in this area was needed. The registered provider had recognised this. All staff had received training in MCA and DoLS but some had failed to understand the guidance in place. The registered manager and regional manager told us they were aware of this and staff were receiving continued support to increase their knowledge and confidence in this area. The regional manager told us that the registered provider was in the process of making changes to MCA documentation.

At the time of our inspection, there were 36 people who had a DoL'S restriction in place; we could see that people had these in place to maintain their safety or to provide support with personal care, eating and drinking and medicines management. The service had a tracker in place which showed when each person's DOLS restriction had been granted and when it was due to expire. This prompted the service to make sure that a review of these deprivations took place prior to the expiry of the restriction.

Some people had 'Do not attempt cardio-pulmonary resuscitation' (DNAR) certificates. All staff spoken with during inspection understood the requirements of these certificates and checked they were in date during reviews of care.

All new staff participated in an induction programme which involved training, shadowing more experienced members of staff and becoming familiar with the policies and procedures of the service. Induction included completion of the care certificate. This is a set of standards which staff are expected to follow at work. We could see that regular reviews took place to monitor staff's progress during their induction and to identify any training and support needs.

We asked people if they thought staff had the knowledge and training needed to provide appropriate care and support to them. One person told us, "Yes, they [staff] are well trained and very helpful." Another person told us, "[staff are] well trained and knowledgeable." Another person told us, "They [staff] are well trained. They know what they are doing."

People spoke positively about staff and told us they had the skills needed to be employed in a caring role at the service. One person told us, "They [staff] look after you very well." Another person told us, "You can see they [staff] know what they are doing." Another person told us, "She knows what she is doing that lady [referring to a staff member]."

All staff participated in regular training, which included moving and handling, fire safety, infection prevention and control, safeguarding, the Mental Capacity Act and Deprivation of Liberties Safeguards, nutrition, communication and first aid. The registered manager told us, "We offer specialised training in Parkinson's disease, dementia and Multiple Sclerosis." We noted a small number of gaps in training, which had already been identified by the registered manager and regional manager and action had already been taken to address this.

Records were in place to show that all staff received regular supervision sessions and an annual appraisal each year. Planned dates were in place for staff supervision sessions. Supervision and appraisals are formal methods of support between staff and their supervisor to make sure any needs are identified. Staff told us they felt supported to carry out their role.

We asked people about the food provided to them. One person told us, "I like the food. It's appetising." Another person told us, "The variety of food is good. If there's anything you want they'll [staff] get it." Another person told us, "Everything's ready when you come to get your food." One relative told us, "There's a good variety, such as stews, casseroles, fish and chips."

Risk assessments were in place for people when they became at risk of dehydration and malnutrition. We could see referrals to health professionals had been carried out when people required further support. Staff worked alongside guidance from health professionals to support people with their food and nutrition.

We were concerned because we did not observe people being offered a choice of food at mealtimes; however we could see people had spoken positively about the quality of the food. We observed people being given a pre-plated meal. Staff told us people were asked for their choice on a morning and other choices were available if people changed their mind. People told us they did not get a choice of meal and when we asked about the menu choices on both days of inspection, we were only told about one choice.

People told us they had access to health and social care professionals when they experienced deterioration in their health and well-being and records confirmed this to be the case. One person told us staff arranged

to take them to hospital for an appointment and had contacted their relative to provide them with an update. Another person told us, "Staff keep an eye on me." Another person told us if they needed to see a Doctor, "They [staff] organise it." One relative told us that staff responded to [person using the services'] needs by getting a GP when they needed one. During our inspection, we observed visits from health professionals taking place and records were up to date.

Good

Is the service caring?

Our findings

Everyone we spoke with told us they were happy living at the service and were happy with the quality of care their received from staff. One person told us, "It's too good in here. I am well looked after. See how nice it is. It's peaceful." Another person told us, "I love it here."

People told us that staff had a caring approach, that they were never rushed when they received care and support and they felt listened to. One person told us, "You know they [staff] are caring." Another person told us, "You can see they really care."

People spoke positively about staff. One person told us, "They chat to me. They ask, 'How's the family?'" Another person told us, "They've got patience." Another person told us, "I like how we are spoken to." We observed a member of staff who came into the lounge and saw that one person's face lit up. The person told us, "She's a diamond. She's a lovely lady she copes with anything."

Staff told us they enjoyed working at the service and enjoyed looking after people. One staff member told us, "I love my job, all of the service users." The registered manager told us, "Staff give one hundred percent to the care of our residents. Care also extends to the families as they too have needs. As a service, we provide care, security, choice, dignity and compassion within a friendly homely atmosphere."

We carried out SOFI observations at the service over the two days of inspection. We found that when people were sat in the lounges, there was very little interaction from staff. We noted people were either asleep or watching television. When staff came into the lounges during our observations, we found any interactions were very limited. Staff also carried out hourly safety checks of people, to do this staff were required to scan barcodes on doors. This meant every room was checked with ensured no-one was missed. Staff did not use this opportunity to interact with people. However outside of these observations, we did see staff interacting with people about the events of the day, past times and television programmes. One person told us, "We have a chat now and again." Another person told us, "We all talk and have a good laugh now and again." Another person told us, "I just talk to them like a friend."

Everyone spoken with during the inspection confirmed they were treated with dignity and respect at all times. One person told us, "They [staff] don't rush people." We observed staff assisting someone to stand using specialist equipment. Staff provided the person with instructions and encouraged the person at each stage until they were stood. People told us that staff promoted their independence by encouraging them to make their own choices and decisions and supporting them to do what they could.

We asked people if they were involved in planning and reviewing their own care. Some people told us they were and some people were not sure. Relatives spoken with told us they had been invited to be involved in this process. Staff spoke about how they tried to involve people in their own care and encouraged people to make their own decisions. They said they also asked relatives to participate in people's reviews of care to support people to have their say. Not everyone could make decisions about their own care and staff told us that they would involve a local advocacy service in these instances. Advocacy services help to provide

people with independent support with decision making. One staff member told us that one person using the service did not have any next of kin and they had contacted an advocate on behalf of this person. Information about a local advocacy service was on display at the service.

Requires Improvement

Is the service responsive?

Our findings

Care records were in place, however we found they did not always contain all of the information required in them.

There were gaps in pre-admission assessments which included information about people's medical history, whether people needed call bells within their reach and if there was important information relating to people's health conditions. This meant staff had not captured all of the information they needed to determine whether people were suitable for the service.

There were also gaps in the information contained in people's care plans. For example, although care plans highlighted the risks to people, they lacked detail. In one person's care records, the record stated, "Unsteady at times." The record did not provide any information about when or why the person could become unsteady, such as on waking, when standing or when unwell. A risk assessment for falls was in place for another person which stated they had experienced falls at the service, however a care plan for 'maintaining a safe environment' stated there was no history of falls. A care plan review for their mobility stated, 'No cause for concern.' This meant the information contained within this person's care records was conflicting. Staff told us the person had not experienced any falls at the service, but they had fallen when they lived in their own home. This had not been reflected in the person's care records.

A care plan for 'Cognition and behaviour' for one person, stated that when this person displayed behaviours which challenge, staff should verbally redirect the person and explain that their actions are unacceptable. We noted a DoLS was in place for this person and questioned whether they would understand the verbal directions from staff. Information in this care plan was not accurate. For example, the record stated staff must know where this person was at all times. The registered manager told us this was not necessary and the one hour observations which staff carried out on this person were sufficient.

Another person's care plan for personal care stated they could be non-compliant with care, but did not state why or the action staff needed to take when this situation arose. When we spoke with staff, they told us this was usually when the person had experienced incontinence and tended to be more compliant with male members of staff. We noted this relevant information had not been included in the care plan.

Daily care monitoring records were not up to date. Gaps in these suggested that people were not receiving that was recorded in their care plans and therefore expected. However, when we spoke with people, we could see they received the personal care they needed. When we spoke with staff, we could see that staff categorised care activities differently and we could see that some staff did not always complete them fully. Although monitoring records we looked at contained gaps, the electronic care system in place at the service contained accurate and up to date information which the registered manager monitored to make sure people had received the care and support people needed and that expected by the registered manager. This confirmed people had received the care and support expected, however paper care records had not been kept up to date.

Risk assessments and care plans did not always contain the same information. For example, a risk assessment for a specific health condition for one person stated that they liked to bathe two to three times per week. However this information had not been included in the person's care plan. A risk assessment for falls stated, "Alzheimer's made [person using the service] prone to falls." However, we noted from the persons care plan records that they experienced low blood pressure and deterioration in their eyesight, which meant they could become disorientated and all of this put them at high risk of experiencing falls.

Nutritional risk assessments were in place when people became at risk of malnutrition, however we found staff did not always follow the guidance within these assessments. Weight loss and weight gain had not always been calculated correctly. We also noted that body mass index (BMI) had been recorded incorrectly. One person's weight was recorded between 45 and 46 kilograms since May 2016 and staff had recorded their BMI to be 23 on each occasion the person was weighed. We noted that this BMI was not possible for the person's height and weight. We also found that for one person in a nutrition risk assessment, the outcome of the assessment placed the person at high risk of malnutrition and they should have been weighed weekly and they had not. In some cases where staff had calculated BMI incorrectly, we noted errors on other risk assessments such as pressure area care and bowel risk assessments. We could see there had been no negative impact to people because of these inaccuracies in recording.

A risk assessment for weight loss for one person was in place because there was a 'risk of weight loss due to poor short term memory.' However, this had not been identified within the key risks of the care records and no weight loss had been recorded. A Care plan for 'Eating and drinking' for this person stated their BMI was 21, which indicated they were underweight. However care plan reviews stated this person's weight had increased. We could not be sure which record was most accurate.

Fluid balance monitoring records showed that people were generally receiving adequate fluids; however in the three people's records looked at we noted no target amount of fluid which each person should intake each day had been recorded. On both days of inspection we noted that the records for these three people were not completed in a timely manner. We checked records at 13:50 and found that no fluids had been recorded in them since 9:00. People and staff confirmed that people had been offered fluids; this meant we could see that staff had not completed the records. We spoke to the registered manager about this during inspection and they told us that action would be taken with staff to ensure they understood the importance of accurate recording of information for people at risk of dehydration.

We spoke with the registered manager about the gaps in people's food and fluid balance records. They told us they were satisfied that people were receiving enough to eat and drink, however action would be taken to improve the quality of record keeping for food and fluid balance records.

Information relating to mental capacity and deprivation of liberty safeguards had not always been incorporated into people's care plans. For example, care plans did not always show if people's application for a DoLS had been granted. Where specific health conditions had been identified in the DoLS, care plans and risk assessments had not been put in place for those conditions. In one person's care records, we could see they did not have capacity to make their own decisions and a DoLS was in place. However, a care plan for 'maintaining a safe environment' stated that they did not wish to self-medicate. We questioned the accuracy of this given the person did not have capacity to make a decision to self-medicating.

Care records for one person stated that staff had lasting power of attorney (LPA) for finance for one person. We noted this was inaccurate because LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. During inspection, evidence was found to show this person's relative had LPA for both

health and welfare and for finance.

Topical cream records were in place for five people looked at which detailed when and where to apply topical creams. From speaking with staff and looking at people's topical creams, we could see that these had been applied, however topical cream records did not confirm if they had been applied as prescribed because records contained gaps. We also noted that topical creams did not contain a date of opening on them. The registered manager told us action would to ensure staff completed these records regularly.

There were gaps in recording on supervision records which we reviewed. We could see that these sessions had taken place, however supervision records had not been fully completed by the staff members involved.

This meant there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans we looked at contained accurate and up to date information and had been regularly reviewed. We found some care records contained detailed information. For example, for one person, a care plan for sleeping included the person's bedtime routine, such as when the person got dressed in their nightwear, how they liked to spend their evening and what linen they liked on their bed. For another person, a care plan to keep the person safe, included information about access to a call bell when they were in bed and the equipment needed for the person to mobilise around the service. Care plans also provided information about specific slings to use for one person with a specific health condition. This meant staff had the information needed to provide care and support to this person safely. Care records were not consistently maintained, which meant that some people were at risk of not having their needs met.

People told us that they enjoyed the variety of activities which were available at the service and felt there was enough to do. One person told us, "It's the exercise I like." Another person told us, "I like it when there are activities." They also told us exercise was their favourite and that, "They [staff] encourage you to go out in the garden." Another person told us, "It's not very often I refuse [to get involved]. They [staff] do try." And, "The youngsters from the school are very good."

The activities coordinator told us that people could do anything they wished and they tried to provide a variety of activities at the service, as well as going out into the community. Information about activities was on display in communal areas of the service. These informed people and their relatives about activities each week and special events occurring at the service. Activities included bingo, floor games, armchair exercises, cake decorating, nail care, pamper sessions and films. The activities coordinator told us that people had received visits from a live animal workshop, which included snakes and spiders. They had also attended a Pantomime and a Macmillan coffee morning. Some people were also involved with the Salvation Army and Wilton choir. At the time of inspection, Christmas raffles were taking place to raise funds for the service. One relative told us, "They'll play skittles or have a sing-a-long, make necklaces and bracelets and every so often they get a 'Turn' in." One person who used the service also played the organ on both floors at the service. People and staff told us they enjoyed this.

Not everyone wanted to join in with the activities; but people told us that staff encouraged them to join in. People told us they could spend their time how they wished and that the service provided newspapers each day.

The activities coordinator showed us a social media page which advertised the service and events which had been taking place. They told us they had received a positive response from relatives because they were able to keep up to date with the service and their loved ones.

On the first day of our inspection, we saw people and staff had made and displayed Halloween decorations and some staff had dressed up for the occasion. We also saw that children from a local school had visited the service on the afternoon for a party with people using the service.

Some people from the service attend a remembrance day service in the local area and people launched balloons in the garden. People and staff also recognised one resident who had been awarded the Ushakov medal by the Russian Federation for courage and bravery during the Second World War.

Information about how to make a complaint was on display at the service and each person had been given a copy of this when they moved into the service. A small number of complaints had been made at the service and records were in place to show the nature of these complaints, details of the investigations carried out including the outcomes and action taken to resolve each complaint. Not everyone we spoke with was aware of the complaints process but told us they would speak with the registered manager if they needed to. One person told us, "I would tell them if there was something but there's never been anything." Another person told us, "I would go to one of the top staff but you don't seem to get any problems." No-one wished to raise a complaint during the inspection.

The registered manager had received many 'Thank you' cards, which had been displayed at the service. We were shown a compliment record received from a relative, who stated, "Always very impressed with the excellent care and attention [Person using the service] received."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, we found the registered manager was not meeting the requirements for Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the registered provider was carrying out audits to monitor the quality of the service; however no action was being taken to address them. From the audits, we could see the same actions had been identified during each of the audits looked at. Action plans had not been developed following these audits. Further to this, audits had not identified the concerns which we had found, such as those for the Mental Capacity Act 2005.

At this inspection, we could see the registered provider had made improvements to their procedures for monitoring the quality of the service. However, improvements were needed in respect of record keeping because we identified a number of gaps throughout care records.

Regular audits had taken place at the service; these included medicines, care records, health and safety, infection prevention and control. Action plans had been put in place when needed and we could see they had been addressed. This meant the same problems had not arisen again. Information about results of audits, accidents and incidents and safeguarding alerts were shared with the registered provider. The regional manager visited the service each month and carried out an audit to monitor the quality of the service. This included reviews of safeguarding alerts and any accidents and incidents which had occurred. Action plans were developed to make sure the service made any required improvements. The regional manager then checked these action plans had been completed at subsequent visits.

The registered manager and regional manager also carried out observations of practice, which they said helped to identify areas for improvement and highlighted good practice. The registered manager and regional manager had already identified our concerns with calculating nutritional risk assessments and BMI scores through their own quality assurance procedures and action plans were in place to support staff. They both told us that staff had not been consistent with the tools in place.

The registered manager told us they regularly monitored the electronic care system in place at the service. They could monitor when people received care and support because the system showed if people were awake or asleep, if they had been offered nutrition or hydration and any personal care staff supported them with. This meant they could take action to make improvements where needed.

Regular surveys had been carried out to assess the quality of the service provided. These surveys were aimed at people and their relatives, staff and visiting health professionals. Results of all surveys had been shared and information displayed in communal areas of the service. The last survey, carried out in September 2016 showed that people rated, care, food, and general care as 'High' and laundry and documentation of people's personal property as 'Requires Improvement.' An action plan had been put in place where people felt improvements could be made. We looked at other surveys carried out at the service. Comments from the staff survey included, "Staff work as a team," And, "Staff know people well and people receive good care," And, "Staff would speak with the [registered] manager, if they needed to." One survey response from a local GP included, "Best home in the area by a long way. People should learn from the

exceptional care they offer."

Staff told us they were happy working at the service and spoke positively about the leadership in place. From speaking with staff, we could see they understood and followed the vision and values for the service. One staff member told us, "I love it here. I like the residents and all the staff are friendly. [Registered manager] is nice, down to earth. I think everything is lovely here. I would be happy for my relative to live here." Another staff member told us, "We have good management. [Registered manager] is approachable."

The registered manager and staff were all aware of the requirements of their roles. We could see staff had reported any concerns to the management team and the registered manager had notified the Commission when required to do so. The service worked closely with the local authority and provided information to them when required to do so.

People and their relatives were kept up to date with events and changes taking place at the service through regular meetings and newsletters. Minutes of these meetings were in place for people and relatives who were not able to attend these meetings.

The service had good links with the local community. The registered manager told us, "We have links with the local councillor in Ingleby Barwick. The local community arranged and paid for our residents to enjoy Christmas lunch at our local pub. Father Clay from St Francis' Church holds mass at our service and some of our residents attend 'Soup of the soul' which is where people come together to have lunch and socialise with other people in the community. Children from our local schools, Barley Fields and St Therese come in to sing and talk to our residents. We are also involved with our local police cadets and have been piloting the use of I-Pads for people with who are unsettled or display heightened anxiety."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) and (2) complete and accurate records must be maintained.