Cherry Lodge Rest Home Limited

Cherry Lodge Rest Home

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 13 November 2017 and was unannounced.

Our last inspection was in September 2016 where the service was rated 'Good' with no breaches of the legal requirements.

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

Cherry Lodge Rest Home accommodates 19 people in one adapted building. At the time of our inspection there were 17 older people living at the home, some of whom were living with dementia.

There was a registered manager in post. 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.

During this inspection we identified three breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities 2014). These related to consent, risk planning, medicines management, record keeping and audits. You can see what action we told the provider to take at the back of the full version of the report. This is the second time that the service has been rated as Requires Improvement.

There was not always a clear plan in place for staff to manage known risks to people. There was a lack of plans in place for specific healthcare needs and the risks associated with them. We also identified shortfalls in the recording of accidents and incidents that meant that the provider could not conduct an effective analysis of them. Safe medicine management practices were not always followed. We identified gaps in the recording of medicines and concerns with how medicines were stored and managed.

People's legal rights were not protected because staff did not follow the Mental Capacity Act (2005). Restrictions were placed upon people before the legal process set out in the Act had been followed.

There were gaps in record keeping that meant care plans did not always reflect people's current needs. The provider conducted their own audits but these were not robust enough to identify concerns that we found during our inspection.

Staff understood their roles in safeguarding people from abuse. Staff had been trained in how to carry out their roles and had regular one to one supervision meetings. There were effective infection control practices in place and staff had received training in this area. Staff felt supported by management and had regular meetings. There were enough staff to meet people's needs safely and the provider had carried out checks on

staff to ensure that they were suitable for their roles.

There was a wide range of activities available that reflected people's interests. People were supported by staff that they got along well with. Staff were respectful of people's privacy and dignity when supporting them and encouraged people to be independent. Systems were in place to provide people with choices and to involve them in their care. Staff provided care to people in a way that was person-centred and reflected their needs. People were prepared food that matched their preferences and their dietary requirements.

The home was in the process of being redecorated and refurbished. Plans were underway to make the home environment easy to navigate for people living with dementia. Checks were carried out on the health and safety of the home and plans were in place to keep people safe in the event of an emergency.

Staff communicated well with each other to meet people's needs effectively. The provider consulted people and relatives on the quality of the care delivered in order to identify any improvements to be made. People and their relatives were aware of how to raise a complaint if they were not happy with the care that they received. We found examples of staff working in line with best practice to meet people's needs.

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.

Gaps in record keeping meant clear plans to manage risks were not in place and there was a lack of analysis of accidents or incidents.

There was a lack of safe medicine management procedures in place.

The provider maintained appropriate infection control practices.

Staff understood their roles in safeguarding people from abuse.

There were sufficient numbers of staff to keep people safe and the provider carried out checks to ensure that staff were suitable for their roles.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's legal rights were not protected because staff did not follow the Mental Capacity Act (2005).

Systems were in place to provide people with a choice. Work was underway to adapt the home environment for people living with dementia.

Staff had access to a range of training courses to support them in their roles.

People liked the food that was prepared for them and their dietary needs were met.

People had access to healthcare professionals where required.

Is the service caring?

Good

The service was caring.

People were supported by staff that knew them well and they got

along with.

Staff involved people in their care.

People were encouraged to maintain their independence and staff respected people's privacy and dignity

Is the service responsive?

Good

The service was responsive.

People had access to a range of activities that matched their interests.

Staff provided care in a way that was person centred. Where people had specific wishes about end of their life care, these were recorded.

People knew how to raise a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were gaps in people's records and existing audits had not identified concerns that we found during our inspection.

Staff felt supported by management and took part in staff meetings.

The provider involved people in the running of the home and conducted surveys to gather people's views.

The provider worked alongside other agencies to improve the quality of people's care.

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

The inspection was prompted in part by notification of a safeguarding concern from a whistle blower. These concerns were investigated by the police and social services and were unsubstantiated.

However, the information shared with CQC through the safeguarding investigations indicated potential concerns about infection control systems and risk management. This inspection examined those risks.

This inspection took place on 13 November 2017 and was unannounced.

The inspection team consisted of two inspectors 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.

We did not ask the provider to complete a Provider Information Return (PIR). This was because the inspection was brought forward due to the concerns raised. Therefore, a PIR was not sent to the provider to complete.

As part of our inspection we spoke with seven people and four relatives. We also observed the care that people received. We spoke with the registered manager (who was also the provider), the home manager, the deputy manager, the activities coordinator and two care staff. We read care plans for five people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We also looked at two staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of meetings of staff, people and relatives.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person said, "Yes, I'm safe. They put a lock on my door yesterday because it didn't have one." Another person told us, "It's the companionship and the attitude of the staff that make me feel safe."

Despite this feedback, we identified some shortfalls in the safety of the care that people received. Risks to people were assessed but in some cases the plans to manage risks were not clear. We identified two instances where there were inconsistencies in records which meant that guidance for staff on how to manage risks was not documented. For example, one person had a catheter and their records stated that they were prone to urinary tract infections (UTIs). There was no recorded plan for staff on how to manage this risk. We did note that staff were recording the person's fluid intake and output, which showed a difference in amounts. The person had been referred to healthcare professionals in response to this and was awaiting a visit from the district nurses. Appropriate actions were being taken to manage the risk, but the provider had not drawn up a clear plan for staff to follow whilst they were awaiting the guidance of healthcare professionals. This did not demonstrate a proactive approach to managing this risk.

Another person's records stated that '[Person] is diagnosed with epilepsy. These seizures can happen.' The risk to the person had not been assessed and a risk management plan had not been recorded and implemented. This person had not had a seizure for a number of years and the provider was in the process of arranging an appointment with the person's neurologist to establish the current status of their epilepsy. Despite the lack of records, staff were aware of the person's epilepsy. We asked staff how they would respond in the event of the person suffering a seizure. Staff were able to outline appropriate actions that they would take, such as calling an ambulance and reducing the risk of injury to the person. Staff told us that they had learned this in their first aid training. This showed that whilst measures were being taken to ensure the person's safety, there was not a person-centred plan in place to manage this risk. This further demonstrated a lack of a proactive approach to risk management. We did identify examples where common risks, such as falls and pressure care, had been assessed and plans were recorded and implemented. However, our findings demonstrated that this did not always happen in a proactive manner.

Actions taken in response to accidents and incidents were not always clear. Where accidents or incidents occurred, immediate actions were taken to keep people safe. For example, one person had fallen and sustained an injury. Staff made sure the person was safe and they were admitted to hospital. The person's risk assessment was updated to include increased supervision from staff when they returned home. There had been few significant incidents since the last inspection and records showed that staff responded appropriately when they occurred. However, there was a lack of a central analysis of accidents and incidents, which meant there was a lack of evidence of lessons being learnt from incidents. The log for accidents and incidents was not kept in one place and forms were not in chronological order. This meant the provider could not identify themes and trends. Where minor incidents had occurred, there was limited information recorded by staff. This further prevented an effective analysis of accidents and incidents taking place. The provider was in the process of updating their record keeping systems at the time of inspection. We made them aware of our concerns during our visit and they took steps following the inspection to

address them. The provider implemented an analysis of accidents and incidents after the inspection. However, we will require further action to address the gaps in records that we identified.

People's medicines were not always managed safely. We identified inconsistencies in records of people's medicines. One person's records stated that they had been prescribed a cream to be applied three times a day but records showed that this was only being applied twice a day. There was no record of a review of this despite it not being administered in line with the prescriber's instructions. Another person had been prescribed a medicine to take at night, but the tablets had run out four days before the inspection and the person had not received their medicine during this time. Some medicine administration records (MARs) contained gaps and did not make clear whether people had received their medicines as prescribed. We also noted that people's medicines records did not identify their allergies, which presented a risk that people may be given medicines that they were allergic to. Where staff had hand written medicines on MAR charts, these had not been double signed. This meant that there was no audit trail for changes to medicines and this showed that best practice was not being followed.

We found one person's medicines had passed their expiry date and were stored loose and cut in half, in a way that made them difficult to count. This was a PRN (as needed) medicine and staff told us the person had not been given it for a long time. However, the prescriber had not been contacted to review if this medicine was still necessary. Another person had a prescribed cream that was out of date. We also found a large backlog of loose tablets that had not been returned to the pharmacy which showed a lack of oversight of medicines storage and accounting. We made the provider aware of these concerns at the end of the inspection and they started to implement changes to address them. The provider introduced additional audits of medicines to improve oversight in this area. However, we will require further action to ensure safe medicine management practice is in place.

The lack of risk planning, shortfalls in recording of risk assessments and incident records, and the lack of safe medicines management practice was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014).

The provider had systems in place to reduce the risk of the spread of infection. This inspection was initiated by concerns raised about infection control procedures. During a visit, the local authority had identified shortfalls in the management of laundry. On the day of inspection, this had been addressed and the provider had purchased new equipment to ensure laundry was separated appropriately and washed in a way that prevented cross-contamination. We observed that the home environment was clean and staff were seen washing their hands and using personal protective equipment (PPE) such as gloves or aprons when necessary. Systems were in place to monitor cleaning at the home. Staff completed cleaning tasks each day and signed them off, demonstrating accountability for work completed. Audits of infection control were undertaken each year.

Staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding and were able to demonstrate a good knowledge in this area. Staff told us the different types of abuse people could suffer and how they would identify them. Staff understood safeguarding procedures and were able to tell us who they would contact to raise concerns. One staff member said, "The best thing is to try and talk to them but always tell them you would have to tell the person in charge. The number is in the office to report to CQC or the safeguarding team." There had been no recent incidents in which staff had needed to raise a safeguarding concern, but we saw evidence of the provider working with the local authority and police where concerns had been raised before the inspection.

There were sufficient numbers of staff at the home to keep people safe. The provider had calculated staffing

numbers based on people's needs and rotas showed that the provider maintained the numbers of staff that they had calculated. We observed that staff were able to meet people's needs and were not rushed. People told us that there were enough staff to support them and they responded quickly. Staff said that they felt the team was sufficient to meet people's needs and they were given enough time to complete care tasks.

The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff files contained evidence of references, right to work in the UK, work history and a DBS check. DBS is the Disclosure and Barring Service. This is used to identify potential staff who would not be appropriate to work within social care. Staff told us that they did not start work until checks were completed and records confirmed this.

People were kept safe in the event of an emergency. The provider had assessed risks in relation to fire and had equipment in place to keep people safe in the event of a fire. Fire alarms were tested regularly and equipment had been serviced and checked. There was a plan for how to evacuate the building in the event of an emergency. Each person had a personal emergency evacuation plan (PEEP) that told staff what support they would need to evacuate the building. There was also a plan in place to ensure continuity of care, should the building become unusable in the event of an emergency.

Requires Improvement

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 people 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 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).

People's legal rights were not protected because staff did not follow the code of practice of the MCA. For example, one person had been living at the home and had been subject to restrictions to keep them safe. The provider had submitted a DoLS application to the local authority, but had not conducted a mental capacity assessment to establish if the person had the mental capacity to consent to their care or accommodation. There was also no evidence of a best interests decision to identify if the restrictions were in the person's best interests. The person's care plan stated that they required an advocate as they had no relatives. The advocates listed on the person's care plan were social services staff. The MCA code of practice states that people should be supported to access an independent mental capacity advocate (IMCA) in these circumstances. An IMCA should be specially trained for this role and the code of practice states that they must not care for or treat the person in a professional capacity. This meant the person did not have appropriate independent advocacy in place to represent their views.

Another person was living with dementia and was subject to restrictions. They had not consented to their care and were not able to leave the home unaccompanied. There had been no assessments carried out of this person's mental capacity. When asked, staff told us that this was because the person did not speak English. This demonstrated a lack of understanding of the principals of the MCA which state that all practicable steps must be taken to support a person to make a decision. In two other instances, DoLS had been applied for but refused because the people had the mental capacity to consent to their care. This further demonstrated a lack of understanding of the MCA. Staff had been trained in the MCA but when we discussed cases with management they were not aware of how it applied to people. After the inspection, the provider told us that MCA assessments had been completed for those that required them.

Failing to follow the correct legal process and principals of the MCA was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014).

In other areas, best practice was followed to enable people to make choices. People's care plans contained information on advanced wishes. These were used to record people's preferences for their care if they were to later lose the mental capacity to make decisions and included decisions around end of life care. People also completed a 'preferred priorities for care' sheet, which recorded their preferences and what their goals were. We did note on the day of inspection there was a lack of decoration for people living with dementia.

The provider told us that this was due to ongoing refurbishment works which we saw during the inspection. Personalised signs were being prepared for people's rooms, along with signage around the home that would help to orientate people living with dementia. They showed us their plan for this. The activities co-ordinator was taking the lead and working with people to create these. We will follow up on the impact of these improvements at our next inspection.

People were supported by staff that were trained to carry out their roles. One person told us, "The staff here are out of this world, they really are marvellous." People and relatives spoke positively about the competence of staff and our observations matched this. Staff told us that the training they were given gave them confidence in their roles. The provider kept a record of staff training and ensured training was regularly refreshed. Training included important areas of care such as health and safety, moving and handling and dignity. The provider had a training centre on the premises that staff used to complete courses. Staff had regular one to one supervision and they told us that this was used to discuss the care that they provided. Appraisals took place each year to measure staff performance and identify any training and development needs. One staff member said, "I did eLearning and the care certificate when I started." The care certificate is an agreed set of standards in adult social care that staff are trained to. Staff told us that they had a thorough induction where they shadowed experienced staff members before working with people. Most staff had also completed additional vocational courses in adult social care such as an NVQ (national vocational qualification).

Training was tailored to the needs of the people that staff supported. For example, the majority of staff had attended training in 'dementia awareness'. We observed that staff supported people living with dementia in a way that demonstrated an understanding of their condition. When one person became anxious, staff were able to distract them by encouraging them to take part in an activity. Staff spoke clearly and repeated themselves as necessary. The staff member later told us that they were aware of how dementia affected that person as their memory has gone to an earlier part of their life. Staff told us that they had received training in dementia care and records confirmed this.

People told us that they were happy with the food that was prepared for them. One person said, "Yes, the food is tremendous." Another person said, "Yes I eat everything, it's good." People's care plans contained information about their food preferences and people received meals in line with these. For example, one person did not like beef and their daily notes showed they had not been served beef. The kitchen had information about people's preferences, allergies and dietary requirements. There was a choice available for each meal and people could choose an alternative if they did not like what was on the menu.

People's dietary needs were met. Where people had specific dietary needs, these were listed in their care plans and staff were able to tell us which people had specific dietary needs. One person was lactose intolerant and this was clear in their care plan and staff told us about this need. The person had meals prepared that were lactose free in line with their dietary needs. Another person required a gluten free diet and a gluten free option was added to the menu each day in response to this. Where people had diabetes, the information was logged in their records and the kitchen prepared low sugar desserts to cater to these needs.

Staff worked together to meet people's needs effectively. The provider encouraged communication between staff with regular handover meetings and communication systems to update staff between shifts. A communication book was used by staff and important messages were passed on. One person had recently had a new bed delivered and the communication book informed staff of when the person had been assessed, when the bed had been ordered and the delivery date. The bed was in place by the time of our inspection. Staff were observed interacting well together and meeting people's needs promptly. For

example, people were served their food swiftly at lunchtime and those that required support to eat were supported as required. People told us that staff got them up at the time that they wished each morning and we observed that people were up and ready in the morning of our inspection. Staff told us that they knew their roles in the team and this meant that care was delivered in a timely manner.

People's healthcare needs were met, but records were not always clear on people's health conditions. As reported in Safe, information on one person with epilepsy and another person's catheter care was not recorded accurately. However, these people had been supported to access healthcare professionals in relation to their health needs. We saw evidence of people being seen by the GP when required. For example, one person had become unwell and fell in their room. Staff responded and the person was seen by paramedics. Staff then arranged for a follow up with the GP the next day who carried out investigations. We saw evidence of people seeing the optician and dentist when required.

Good

Is the service caring?

Our findings

People told us that the staff that supported them were caring. One person said, "They (staff) are very patient with me." Another person said, "Absolutely brilliant, (the staff are) the most loving and caring people that I know." Another person told us, "The carers are brilliant, absolutely wonderful."

People were supported by staff that they got along well with. We observed staff interacting with people warmly and spending time with them. For example, in the morning staff were observed doing word searches with people. Another person asked staff for a stool to rest their legs on. Staff got them one and said gently to the person, "You don't need to wait for us to come over, just ask any staff and they will get you one." The person smiled and said they would. Later in the day, staff joined in a discussion with a group of people. People looked comfortable with staff and were observed smiling and laughing whilst interacting with staff. Throughout the day we heard staff complimenting people which people responded warmly to.

People and relatives praised the caring nature of staff and told us they were supported by staff that were consistent and familiar to them. People were supported by staff who worked with them regularly, as the provider rarely used agency staff. Staff were able to tell us important information about people's needs as well as their backgrounds. For example, one person grew up in a certain area and staff were aware of this. Another person had a favourite pet cat before they came to live at the home and staff were able to tell us about the person's pet. The impact of shortfalls in recording that we identified during the inspection was minimised by the fact that people were supported by regular staff that they got on well with.

Staff involved people in decisions about their care. People were asked about their preferences and wishes when they came to live at the home and these were revisited in reviews. Staff had a good knowledge of people and we observed that staff knew how people liked things done. For example, a staff member prepared hot drinks for three people and knew what drinks they all liked and whether they liked sugar or milk in their drinks. People were given choices at mealtimes and people told us that they had opportunities to choose activities that took place at the home. Regular meetings took place where people were asked to give ideas on meals and activities. People told us that they enjoyed these meetings and felt empowered to contribute. This created an inclusive atmosphere at the home where people felt free to start their own activities. We observed a group of people having a table top discussion which they had facilitated themselves. The activities co-ordinator at the home told us that they worked around people's wishes and allowed them to take the lead wherever possible.

People were supported to retain their independence. People's care plans recorded what they were able to do themselves and informed staff of how to encourage people. One person was reliant upon staff for a lot of personal care tasks, but they were able to wash their face and hands and apply make-up. Their care plan made this clear and a staff member who supported the person told us that they supported them in this way. Staff said they provided prompts and supervision to ensure that the person was safe whilst they completed these tasks. Staff recognised the importance of enabling people to be independent. One staff member said, "We always ask people what they need help with. One person does everything themselves but just likes us to be there for reassurance."

Staff were respectful of people's privacy and dignity when providing care. Staff were observed kneeling down to speak to people, ensuring that they were at their eye level. Staff spoke in a calm tone and repeated themselves gently when necessary, enabling positive communication with people. Where personal care was provided, this was done discreetly. Staff were observed knocking on people's doors and waiting for permission before entering. The provider had given staff training in dignity and the majority of staff had attended this. Staff demonstrated a good understanding of how to provide care to people in a respectful manner. One staff member said, "You knock on the door and introduce yourself. Say what you are here to do and make sure they agree by asking their permission. Make sure the curtains and doors are closed. Give people choices regarding what they want to wear or if they want to stay in their room."

Good

Is the service responsive?

Our findings

People had access to a range of activities. One person said, "I get involved in absolutely everything." Another person told us, "I'm not able to crochet anymore because I can't see much now, but I enjoy listening to music and talking with staff."

The provider arranged regular activities for people, based upon their interests. People had their say on what they liked to do and activities were arranged in line with these preferences. For example, one person living at the home used to enjoy boxing. In response to this, the provider had arranged for a semi professional boxer to visit the home to switch on the Christmas lights. We saw photographs of recent activities that included visits from a local scouts group and an Alice in Wonderland themed party in the garden. The scouts had visited for bonfire night and built a 'bonfire' with people in the home, people told us that they had really enjoyed this.

Regular activities such as games, arts and crafts, outings and films also took place at the home. At the time of inspection, a project was being undertaken to make a family tree. This involved people decorating and adding pictures of themselves and staff to a large mural on the wall of the home. We observed an arts and crafts activity taking place and people were engaged and appeared to be enjoying it. Staff were very interactive, involving people and encouraging them as required.

People were supported to do things that were important to them. Where people had specific religious or cultural needs, staff were aware of them and we saw evidence of people being supported to meet them. For example, one person was a practicing Buddhist. They told us that they liked to have time to meditate each morning and staff were aware of this and allowed them enough time before supporting them each day. There was a regular Christian church service at the home and people who wished to were supported to attend church. At the time of inspection two people had recently attended a Remembrance Sunday service at a local church and told us that staff had been open and encouraging in supporting them to do this.

People were supported to maintain relationships that were important to them. Relatives told us that they could visit at any time they wished and there was no restrictions on visiting. Relatives said that staff were available when they visited and provided updates on visits as well as by telephone. Some people who lived at the home had relatives who lived a long way away. The provider had set up technology that meant people could speak to relatives through Skype which was connected to people's televisions. People told us that they valued this support from the provider to keep in contact with relatives and friends.

People received personalised care. People and relatives told us that staff provided care that met their needs and matched their preferences. We did identify two care plans where information was missing, which we have reported on further in the Well-led domain. Despite this, people's preferences and routines were met as they were known to staff. Staff had a good understanding of people's needs and what was important to them through working with them consistently. For example, one person told us that they liked to get up late and their care plan recorded this preference. Staff were also aware of this person's routine and daily records showed that they got up at their desired time. Where people had needs relating to their dementia, these

were met. One person had started to lose some of their longer term memory and their care plan identified this. The person took part in regular reminiscence activities and these were recorded. Where other people were living with more advanced dementia, they were observed interacting with 'fiddle mits' which were textured items that people engaged with through touch.

The provider was considerate of people's needs at the end of their life. At the time of inspection, nobody was receiving palliative care but care plans were in place for end of life care and these documented people's advanced wishes. The end of life care plans involved people, their relatives and healthcare professionals. People recorded their wishes such as whether they wished to be admitted to hospital. One person had a health condition that meant they were approaching the end of their life. A care plan had been drawn up that documented that the person wished to pass away at the home and their relative was to be contacted. The care plan documented that relatives would like support after the person died and staff told us that they provided this through referral to voluntary organisations.

People and relatives were aware of how to raise a complaint. People and relatives told us that they knew how to raise any concerns and they were confident that the provider would deal with them. There was a complaints policy in place and people were regularly reminded on how to raise concerns at meetings and reviews. There had been no complaints since our last inspection and a survey had taken place two months before the inspection which provided an opportunity for people to raise concerns. People and relatives had fed back that they were happy and had also stated that they were aware of how to raise a complaint if they wished to.

Requires Improvement

Is the service well-led?

Our findings

We received mixed feedback on the leadership at the service. One person said, "The level of attention is far superior than I expected." Another person told us, "Yes, I do think it's well-led. It's absolutely super." However, one person said, "You don't see the manager often." A relative told us, "The staff do their very best but how much support they get, I wonder."

The provider did not have effective systems in place to ensure up to date and contemporaneous records were kept for each person. We identified information missing from care plans and risk assessments. For example, one person's care plan stated they were at risk of pressure sores and should be repositioned regularly. We found no repositioning chart in the person's room and staff said this had been discontinued some time ago, but the person's care plan had not been updated to reflect their current needs. Another person had lived at the home for ten days and had no assessment or care plan in place. The person had been to visit the home for a day four months before being admitted and some hand written information from relatives had been obtained. However, this information had not been added to the person's care plan since they had come to live at the home. As noted in the other domains, staff knew people well and had a good knowledge of their needs. This reduced the impact of the missing information, but the amount of information missing from people's care records demonstrated a lack of good governance at the home.

Audits were not robust enough to proactively drive improvements at the home. Where we identified gaps in records, no audit had picked these up. We did not see evidence of a recent audit of records that would have picked up on missing information from care plans. Audits had taken place in areas such as infection control, health and safety and medicines. However, the audit forms contained little information and they had not identified known issues. For example, the local authority identified shortfalls in infection control before our visit. The provider had taken steps to address this but their last audit had not identified the concerns. Where we found shortfalls in medicine management practices at the home, the last medicines audit had not identified these. There was not an ongoing improvement plan at the time of inspection. Management told us that they addressed things as they found them but will consider implementing an ongoing plan to document and track improvements at the home.

We noted that there had been recent changes to management staff that had impacted on leadership and governance at the home. After the inspection, we gave feedback to the provider and they took immediate steps to address our concerns. The provider introduced additional audits after the inspection and work was underway to update care plans. Whilst this was a positive response to our concerns, we will require further actions from the provider to ensure good governance at the home is sustained.

The lack of accurate record keeping and failure to conduct robust audits to improve the quality of the care that people received was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014).

Staff felt supported by management. Despite feedback from one relative that staff did not appear supported, staff told us that they had appropriate support in place. One staff member said, "Sure we can

speak up. It's a nice place to work, everyone is open." The registered manager was also registered to manage another service. A home manager and a deputy manager supported the day to day running at the home and provided line management to care staff. Staff had regular supervision and appraisals and we observed that the management team worked alongside staff when supporting people. The home manager's office door was open and staff had easy access to management. Staff meetings took place but we noted there had only been three in the last year, which limited the opportunities for staff to give suggestions and feedback on the running of the service.

We recommend that the provider reviews their systems for updating staff and involving them in the running of the home.

People had opportunities to give feedback on the home. Meetings took place in which people and their relatives could have their say in areas such as food and activities. At the last meeting people had fed back positive comments about their care. People were asked if there was anything they would like added to the menu or the activities schedule. People had requested that music be played in the afternoons. The provider actioned this and we heard music playing during the afternoon on the day of inspection. The provider also conducted surveys to gather the feedback of people and their relatives. There had been two surveys in 2017 and the feedback was mostly positive. In the last survey one person had said they were not aware of the complaints policy so the provider had addressed this. The rest of the comments praised the caring nature of staff and the home environment.

The provider worked with other agencies to improve the quality of the care that people received. We saw evidence of the provider working with community health services, such as the district nurses, to meet people's individual needs. The provider also worked with the local authority quality assurance team to bring about recent improvements to infection control. The provider also built links with community groups, such as the local scouts group who attended for a recent activity. They had also arranged a Christmas carol service with a local school as people responded well to involvement of children in activities.

The provider had a vision to continue improvements at the service. Redecoration had been carried out since our last inspection and the provider had plans to implement improved care planning systems. Refurbishment works, involving people, were underway as a part of the provider's ongoing vision to improve the service.

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 11 HSCA RA Regulations 2014 Need for consent Staff did not follow the code of practice of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of planning for individual risks and a lack of safe medicine management practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not keep accurate and up to date records and quality assurance audits did not identify known concerns.