Bupa Care Homes (CFChomes) Limited

The Mellowes Care Home

Inspection report

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Gillingham
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Mellowes is a nursing home that is situated on the outskirts of Gillingham. Accommodation is provided over two floors. A passenger lift enables access to the upper floor. All rooms have en-suite toilet and washbasin facilities. The Mellowes has three communal lounges and a dining area. The home has landscaped gardens and a patio. The Mellowes is registered to support 45 older people, at the time of the inspection there were 36 people living at the home.

We inspected The Mellowes in November 2015. At that Inspection the service was rated Good. At this inspection we found the provider to be in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations, 9, person centred care, 11, consent, 12, Safe Care and Treatment, 18, staffing, and 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.' At the time of the inspection the registered manager had just taken back full responsibility of the home. They had previously been supporting the management of two of the provider's homes.

We found a number of areas where care was not completely safe and where staff needed better information and guidance on how to support people's emotional and social needs. Procedures to assess and monitor risks to people's health and safety were not always followed. Where people were at risk of dehydration, fluid intake levels had not been recorded.

Risks to people were identified but measures were not always implemented to reduce the risk. Some risks had not been fully assessed, and measures to reduce the risk to people were not fully effective or agreed with other health professionals.

Where people required specialist equipment such as specialist chairs, pressure mattresses, mobility aids or hoisting equipment, these were provided. Although staff told us they had been trained in moving and assisting, people told us they were not always supported to transfer safely.

Improvements were needed to make sure everyone received person centred care and had opportunities for social stimulation. This was a particular concern regarding the care of some people who remained in their rooms. There was an activity programme in place, however records and observation showed some people were left for long periods of the day alone.

People had mental capacity assessments in their care plans. However. although we found evidence of

decision specific mental capacity assessments, few had been completed to include evidence of subsequent best interest decision making involving all relevant parties.

A recruitment procedure was in place and staff received pre-employment checks before starting work with the service. New members of staff received an induction which included shadowing experienced staff before working independently. There was no evidence of supervision or support over a period of six month for new staff or for existing staff. This meant there was a risk new staffs were not being appropriately supported within their roles.

Registered nurses were always on duty and held the responsibility for leading the shifts, which meant people's healthcare needs were monitored. People told us they did not always receive support in a timely manner. Staff were seen to be task focused. One visiting health professional told us, "I am concerned at times that things don't always get done as quickly as requested".

Systems were in place to ensure people received their medicines safely. All staff received medicine administration training and had to be assessed as competent before they were allowed to administer people's medicines.

People's relatives told us they were made to feel very welcome when they visited The Mellowes, they could visit at times convenient to them, there were no set visiting times or unreasonable restrictions.

Relatives were confident they could raise concerns or complaints with the registered manager and they would be listened to. The provider had systems in place to collate and review feedback from people and their relatives to gauge their satisfaction and make improvements to the service.
The provider and registered manager had a number of audits and checks in place to review how the service was running. These had not identified the concerns on this inspection.

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

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 were not always safe.

Risks to people were identified. However where risk assessments were in place they were not always followed to prevent further risk to people.

Safe recruitment procedures had been followed before new staff began working in the home.

People received their medicines when they needed them from staff who were competent to do so.

Is the service effective?

Requires Improvement

The service was not always effective

People's capacity to make decisions about their lives had been considered or assessed. However applications had not always been submitted for people whose liberty may be restricted.

People were supported by staff who had not always received regular supervision and appraisal to monitor their practice or identify areas where further training or guidance may be necessary.

People were offered a choice of meals and drinks that met their needs and preferences.

People's healthcare needs were assessed and they were supported to have regular access to health care services

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were task focused. Staff did not always identify or respond when people had spent a long time alone.

People were supported in a way that did not always consider

their dignity and respect.

People and their relatives spoke positively about staff and the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always have access to a range of activities meaningful to them.

People's care plans included up to date information, daily records held insufficient evidence of people's needs being responded to.

There were systems in place to collate and review feedback from people and relatives on the service received.

There was a system in place to manage complaints. Relatives told us they knew how to raise any concerns or complaints and were confident that they would be taken seriously

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality of the service provided to people was monitored and where there were shortfalls these were not always identified.

The manager promoted an open culture and was visible and accessible to people living in the home, their relatives and the staff.

People were supported and cared for by staff who felt supported by an approachable manager.

The Mellowes 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 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. This was a comprehensive inspection.

This inspection took place on 10 and 11 May 2017 it was carried out by one inspector and two specialist advisors and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 13 people living at the home and five visiting relatives about their views on the quality of the care and support being provided.

We also spoke with the registered manager, regional director, resident experience manager, training facilitator three nurses and 11 staff members including the chef and a laundry assistant. We also spoke with four visiting health professionals. We looked at documentation relating to eight people who used the service, four staff recruitment and training records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Although people and relatives said they felt safe, we found examples where people were potentially at risk. Risks to people had been identified. Where people required specialist equipment such as specialist chairs, pressure mattresses, mobility aids or hoisting equipment, these were provided. However we found were people were at risk of falls and dehydration the risks remained.

There were procedures in place to assess and monitor risks to people's health and safety. However, the procedures were not always followed. Where people had been assessed as being at risk of dehydration, fluid charts had not been completed regularly. When we asked staff why the charts had not been completed they said they added information into care records when fluids had been given. The entries in the care records did not record how much fluid people had been given or drank. Fluid records which had been completed had not been totalled each day to enable monitoring of peoples overall intake.

When people had experienced falls these were reviewed monthly and actions were taken where necessary to reduce the risk of further falls. However, we saw evidence that some risks had not been fully assessed, and measures to reduce the risk to people were not fully effective or agreed with other health professionals. For example, the registered manager informed us they had changed the way one person was supported to prevent further harm from falls. Minutes from a safeguarding meeting held on 21/02/2017, identified the assessed guidelines to support the person to transfer safely although clearly documented in the person's care plan had not been followed by staff resulting in an injury to the person. The guidelines clearly identified the safest way to support the person to maintain their wellbeing, personal dignity, physical and mental health, emotional wellbeing and skin integrity. Although the new method of support was preventing falls, the person was at higher risk of skin tear. The method of support was contrary to professionals advice. One visiting health professional told us, "There have been no meetings to agree this method of support is in the person best interest. We have concerns the agreed actions from the safeguarding meeting have not been followed. The agreed method of support has not been followed and we have not been informed of the change in support". We have raised these concerns in the past with the management team and will do so again". The registered manager informed us they had reviewed if the person's needs could be met at the service, they said "It is not ideal but we feel it is the safer if the person is nursed from a lower position."

People were unable to join others in lounge areas on some occasions, for example. One person was being supported in their room with fire doors outside their room closed. The person care plan stated the person, 'Likes to meet people, but due to confusion may get anxious". The care plan stated the person was at risk of falls and needed one to one observation at all times. One member of staff told us "We know [person's name] wants to go to the lounge, but we don't have the staff to support them so we have to keep the corridor doors closed. On the second day of the inspection, the person was seen in the lounge. On occasions there were no staff in the area to observe the person. We addressed our concerns with the registered manager who agreed the person should not have been left alone.

Care records contained risk assessments in relation to falls, moving and assisting, tissue vulnerability and nutrition. Although aids were available and staff had received the correct training to support people with

moving and assisting, we found people were not always safely supported to move. For example, one person told us, they hadn't felt safe when staff supported them to move. They told us, "My legs were perfect when I moved in here; they [staff] hurt both my legs whilst helping me to move. The person was still receiving treatment for their legs and told us, "It is still very painful". Staff confirmed the person's legs had been 'hurt' whilst the person had been supported on a stand aid. An accident report written on 07/4/2017 in relation to another person evidenced that they had been 'hit on the arm of the hoist' during a transfer.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment.

People received their medicines from staff that had received the appropriate medicine administration training and had been assessed as competent before they were allowed to administer people's medicines. Medication administration records were correctly completed to show when medicines were administered or refused. Medicine administration records had been completed after each medicine had been administered and there were no unexplained gaps. We were informed there had been two medication errors in the past three months. The registered manager told us audits were completed by the registered nurses at the end of the day. Any medicine errors were investigated and lessons learnt. This included additional training if required.

Staff understood when to offer medicines that were prescribed on an 'as required' basis. Medicines were stored securely in medicine trolleys that were locked when not in use. There were secure storage facilities for controlled drugs, and for medicines that needed to be stored in a refrigerator. We looked at the recording of medication fridge temperatures. These were within normal levels. There were clear specific sheets of instructions including the rationale for administration and restrictions on administration.

The provider had a robust recruitment procedure. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and carrying out Disclosure and Barring Service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Staff told us they had not been able to begin work in the home until all checks had been completed and records seen confirmed this.

The registered manager told us they always had sufficient staff on duty. They informed us they used a dependency tool to determine the amount of staff required on each shift. Staff told us there were lots of new staff and many staff had left, or were planning to leave. One member of staff told us, "We are told we have the correct level of staffing, but they don't take into consideration people's high dependency needs". The registered manager told us they did take into consideration individual support needs. They told us, "We try not to use agency but if we do we ensure the same carers come into the home, we are also able to share support around our other homes." Other comments from staff in regards staffing levels included "There is a big turnover of staff here, people leave to work in other homes in the area". "We don't get time to spend with people as we are always busy". "We are a great team and help each other out". "We could do with more staff to give us more time with people". People told us they felt safe living in the home and had confidence in the staff. Staff were seen to be busy with personal care throughout the day. We looked at four weeks of rota that showed the correct levels of staffing as discussed by the registered manager.

Staff received training in how to recognise and report abuse during their induction. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe.

People were protected from the risk of infection. The home was well maintained and appeared clean and tidy throughout. There were clear housekeeping schedules and we observed regular cleaning of the premises during our inspection. There were sufficient supplies of personal protective equipment (PPE) for staff located around the premises.

Requires Improvement

Is the service effective?

Our findings

There were always registered nurses on duty that led the shift and monitored people's healthcare needs. People told us they could seek advice and support from nurses whenever they needed it. However we found sometimes people's needs were not always met effectively.

People did not always receive effective support. For example one person required support with dressings the person told us, "I have to wait until very late at night there is only one nurse on duty at night, they have other people to see." Relatives also raised concern support was not being given in a timely manner. The person's care plan clearly documented the times the support was to be given by the health professional involved. We discussed the concerns with the registered manager who informed us they would ensure the person received the support they required at the stated times with immediate effect. Another person's care record told us they were awaiting a speech and language referral (SALT) due to risk of choking. The records informed us the person's dentures were loose. Staff were guided to 'ensure only the lower denture were in', when the person was eating. There were no requests for a dentist to visit the person. This meant people were not getting effective support in a timely manner.

People were supported by staff who had received training at the start of their employment to ensure they had the basic skills and knowledge to meet people's needs effectively. A member of staff who had recently begun working in the home told us they had received a good induction which included a period of 'shadowing' experienced members of staff. The registered manager told us all new staff had a two week induction period followed by a six month probation period. During the inspection we met a number of staff who had recently been appointed. Staff told us following their two week shadowing a senior member of staff they had not received any additional monitoring or discussion in regards their competency or probation period. There were no records in staff files which evidenced the support received or competency checked throughout the induction or probation period. The registered manager told us, all new staff were supported by team leaders, however there no completed checks to evidence this in staff files. This meant there was a risk new staffs were not being appropriately supported within their roles to ensure their competency. The provider informed us they had introduced a new competency assessment tool in April 2017 and were currently waiting to use with the two members of staff who had been recently been employed.

Supervisions were held for staff in group setting at team meetings. Following a safeguarding concern sent to the local authority and Care Quality Commission in January 2017, the action plan sent from the provider stated "We will undertake supervisions with all care staff over the next few weeks to ensure that they are fully aware of the importance of reading care plans and communicating accurately". Records were not shown which identified this action had been taken". The registered manager told us group supervisions had taken place; they were unable to show us any supervisions that had been completed to identify performance issues. The group supervision records did not identify any areas of discussion in regards staff performance.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

The Mental Capacity Act 2005 provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. Although we found evidence of decision specific mental capacity assessments, few had been completed to include evidence of subsequent best interest decision making involving all relevant parties. For example, a relative had lasting power of attorney for finance alone but had signed consent forms for care which was not in accordance with the care plan. Another person was deemed 'not for CPR' in 2015 whilst in hospital. The records state this was discussed with the person family as the person was 'confused'. There were no records of MCA or best interest decision or subsequent review since the person had moved to the service as the person was no longer confused this meant the person would be able to make their own decisions.

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). One visiting health professional raised concerns DoLs applications had not been submitted to the local authority following a request to the provider to complete one in February 2017. We discussed this with the registered manager who told us they had applied for the DoLs application on 08/05/2017. This meant that people were at risk of being deprived of their liberty and human rights without the legal authorisation. The registered manager told us they had requested further DoLs applications and were awaiting the completed paperwork.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for Consent .

Relatives told us they thought staff were trained to meet the needs of their family member. One relative told us, "Yes, staff seem to have the right training". A training facilitator told us induction training was linked to the Care Certificate Standards. The Care Certificate Standards are standards set by Skills for Care to ensure staff have the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. They said, "We link closely with all the homes. If we feel someone needs additional training we feed this back to the registered manager of the home" Staff confirmed they had completed training. However some staff felt they needed additional training to support them in their roles. Nursing staff informed us they were still awaiting specific training to enable them to support people. One nurse told us, they were "Well stretched" and the service was about to embark on additional training for student nurses". Other staff seemed unsure how to support people in an emergency situation. For example, people had been identified as possible choking risk. We asked two members of care staff what they would do if someone was choking. Both seemed unsure and told us they would fetch a nurse. The residents experience manager told us, they were currently working on their training matrix to ensure all staff remained up to date including basic first aid training.

The service had a four week rolling menu with two choices of meals each day. The menu had recently been discussed at the residents and relatives meeting by the chef ensuring the choices people liked were included on the menu. Alternatives, such as omelette, baked potato and sandwiches were available if requested. On one of the days of the inspection we heard a person get upset over the size of their meal and content of their meal, they told us, "I really want to have some fresh fish and I want my dinner on a small place". The following day we saw the chef had listened to the person and had met the person's request. They told us, "I'm so looking forward to eating this lovely meal". The chef told us they were planning on purchasing smaller plates for those who wished to eat smaller portions.

We saw the dining tables were presented well with, flowers and a lunchtime menu cards offering two choices of main course and dessert. People who did not go to the dining room had their meals served from a hot trolley. The majority of people thought the food was, "Good", or "Excellent". One person told us, "The food is very good here; we get offered food from the night menu at night if we are peckish".

People had access to external health and social care services as needed. Most people were supported from one local GP surgery. People could see health care professionals when they needed to. A visiting health professional told us, "There are some excellent nurses here, some need additional training and I understand find it difficult to get it."

Requires Improvement

Is the service caring?

Our findings

People received a service that was not always caring. Although some people told us they preferred to stay in their rooms, "as it was easier" others seemed to have little opportunity to leave their rooms. Staff told us "They did not have time to get people to the lounge area", and when they did it was "Sometimes difficult to get people ready for the night staff". One person's who remained in their room care records showed they had been visited on three occasions by staff in one day between the hours of 7.20 and 01.08. On the following day they were visited four times between the hours of 6.05 and 23.29. All entries in the records indicated the visits had been for personal care or medication. This meant people were at risk of isolation. One person told us, I went down at Christmas but not bothered since". One visitor told us, "I come in to try to encourage [person's name] to come out or downstairs. They don't seem to want to bother anymore." Where people were able to be supported out of their rooms they seemed to lack motivation. One person told us, "I can't be bothered any more".

The service was task focused. People had their physical needs, such as washing and dressing met, this took up the majority of staff time meaning that once people had received personal care there was very limited interaction with staff until they required another task to be performed. One health professional told us, "There have been several occasions recently that I am aware of where patients are being left in their beds rather than hoisted out, leaving patients isolated". One member of staff told us, "People do stay in bed". A visitor told us, [person's name] has not left their room since October 2016. I am here to try to encourage a trip out". We later saw the visitor who told they had not been successful in getting the person out for a trip. One visiting health professional told us, "We see people just sitting around, activities are poor, and people don't seem to go out at all, you never see anyone in the gardens. People need fresh air and to go for a walk". One member of staff said it would be so nice if we could take people out for a coffee, were not allowed to have any transport, but I don't see why we can't use taxis". People told us if they were going out it would be with family members. One person said, "I'm lucky I have family that take me out." People told us they had opportunities to go out and about with family and friends. On both days of the inspection people were seen being taken out for the day by their visitors.

People who remained in their rooms had 'half hourly checks. Staff were observed to tick the chart without engaging with the person. People spent the majority of time in their rooms either in bed or sat with their eyes shut in their chairs. All rooms had the television on although few seemed to watching or listening. One person's care records stated they enjoyed social interaction, liked their door ajar and classical music. Records and observation showed the person was left for long periods of the day alone. On both days of the inspection the person's door was not ajar; they were unable to see what was happening outside of their room due to the position of their bed. The television was playing background radio music, which was not classical. This meant the care plan and person preferences were not being followed. We discussed our concerns with staff, who then visited the person. The person was heard to engage and seemed to enjoy the interaction. One member of staff told us, "We don't have time to sit with people." This meant the support people were receiving was not responsive to people's individuality and changing needs.

People were treated with dignity and respect. For example observed actions and overheard conversations

indicated that the staff were empathic and kind. However before entering although they knocked on doors – they did not though wait for a response before actually entering.

People and relatives told us staff were friendly and caring. One person told us, "Yes the staff are awfully kind". During our inspection we observed some caring interactions from staff towards people. For example, staff engaged in friendly conversation when bringing people into the lounge area. One staff member commented on how "Lovely you look today", to one person sat in the lounge area. However the comments were made as staff prepared to go and support another person. People were supported by staff who knew them. Relatives thought staff knew their family member well. Comments included, "Yes they know what they like and don't like". And "[name] doesn't like to make a fuss, but they always tell them it no bother".

There were a number compliments regarding the support people received. Thank you cards echoed comments made by people about the staff. One card thanked staff for their 'care, support and affection.' Another said "Thank you to all carers, caterers, cleaners, entertainers, and gardeners. Thank you for all your kindness, care, love you extended to [person's name] in her dying days.

People were supported to maintain relationships with their families and friends. People told us their relatives could visit them without any unnecessary restrictions and they were made welcome when they visited. One relative told us, "We are always treated politely by the staff, without exception staff are very kind". Another person told us, "All the staff are very kind, it lovely and quiet here".

Each person who lived at the home had an emergency evacuation plan. These gave details about how to evacuate each person with minimal risks to people and staff. An emergency box was held inside the main doorway containing personal details of all people living at The Mellowes, and included staff members personal contact details. On both days of the inspection the box was unlocked. This meant people's confidential information could be shared without their knowledge.

Requires Improvement

Is the service responsive?

Our findings

The service was not fully responsive. People received a service that did not always respond to their individual social needs, some people's records showed they were offered very little stimulation or activities. Care was not person centred, often what was written in the care plans following the pre assessment was not followed out in practice.

People received a service that did not always respond to their individual social and emotional needs. Some people's records showed they were offered very little stimulation or activities. People's care plans included up to date information. Staff were seen to consistently write in the care records. Daily records held insufficient evidence of people's needs being responded to, they identified if the person had been seen. Records were repetitive and did not reflect how the person was feeling, whether their mood was high or low or what they had been doing. We discussed our concerns with the registered manager who told us they would be reviewing how staff recorded their interaction with people. Following the inspection the registered manager told us they planned to change the way care records were stored and recorded.

There were limited and inconsistent arrangements to meet people's social and recreational needs. There was an activity programme and newsletter in place. The newsletter gave information of forthcoming events such as, move and grove, pet care and quizzes. At the time of the inspection baby chickens were hatching and people who could get to or had been supported to the area were able watch them hatch. One person's care record stated they loved gardening and garden centres. They told us they would "Love to go to the garden centre for a coffee." We spoke with the activity co coordinator who agreed that people had not been supported outside the home due to lack of transport. They hoped with more support to the activities people would be able to enjoy trips out in the summer.

On the second day of the inspection outside entertainers were seen to be entertaining a number of people in the lounge. Although some people were seen to be supported into the lounge to take part in the activities, many remained in their rooms. One person told us, "They said they would take me downstairs to see the chicks, but when I ask they tell me they are too busy. I'm not going to bother now". Daily records did not identify what activities or stimulation people were offered who remained in their rooms. Records showed when an activity coordinator had called in to see people in their rooms for a 'chat' but did not highlight how long they had stayed or what interaction or activity took place. One member of staff told us, "We would love to take people out but we have been told we can't have a mini bus". One person told us they wished to go to the seaside before they died and to play the piano. We asked a member of staff how this wish could be accommodated, they told us "We will have to bring some sand into the home".

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person centred care.

While the basic care plans contained good information we have highlighted elsewhere in this report areas where the care plans contained insufficient information about specific areas of people's needs, such as emotional and social needs. People's personal care needs had been assessed and plans had been drawn up

to agree how staff should support them. We found inconsistencies between the pre assessment and the care plan for example, one person's pre assessment states they need two members of staff with them due to their risk of falls. This had been crossed out and one member of staff written. The changes were not dated and the entry unsigned. One visiting health professional told us, "Support is very task orientated, and I don't feel staff are encouraged to use their imitative, or encouraged to think 'outside the box'. Another health professional told us, "I am concerned my correspondence in regards the people I support are not responded to."

There was complaints policy and procedure. This gave people information about how to make a complaint and the timescales they could expect a response. People and their relatives said they would not hesitate to make a complaint and they were confident any concerns would be addressed. However, they told us none of their issues had escalated into formal complaints.

Requires Improvement

Is the service well-led?

Our findings

The service was not well led. The registered manager had been overseeing two of the provider's homes, for a period of time. They told us their time had been split between the two services, and they had the support of a deputy manager, and resident experience manager in their absence. On the week of the inspection they had returned to full management of The Mellowes. The provider had a comprehensive system in place which included regular audits by the registered manager, heads of department and senior management team within the company. The registered manager told us, they walked around the home daily and the findings and any actions were shared at the weekly head of department meetings. One visiting health professional told us, "I am concerned at times that things don't always get done as quickly as requested". There is nothing specific I want to discuss, but lots of niggles things that could turn into one big major thing. The carers work really hard. I don't think the registered nurses have very much support. There is no leadership."

We found the provider and registered manager did not have effective quality assurances systems that provided assurances that people received appropriate, safe and good quality care. During the inspection we found inappropriate care practices in regards monitoring of people individual needs. Poor recordings in respect of people's fluid intake and hydration needs. Care plan reviews did not always identify impact of health needs, or actions taken to improve well-being. Daily records did not identify what activities or stimulation people were offered. The group supervision records did not identify any areas of discussion in regards staff performance or development. People using the service were at risk of isolation, records did not reflect their likes dislikes wishes and aspirations were being met. All of these issues had not been identified through the provider's, or the registered manager's monitoring systems.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

Staff told us the registered manager was approachable and accessible and they felt confident in raising concerns with them. The registered manager told us they had a commitment to promoting an open door policy where staff could approach them with concerns. They said they regularly walked the floor, spent time observing staff and giving them feedback to support their development and promote best practice. One staff member told us, "I hope things improve now the registered manager will be here all the time". Another member of staff told us, "I'm glad the registered manager is back."

The manager also held meetings, which included, staff meetings and head of department meetings. The registered manager told us, this ensured they were to be kept up to date and able to pass on information on the provider of any concerns. Audits were in place, for example the registered manager told us the nurses completed 10% of all care plan audits per month, they told us, "This ensures all our care plans are reviewed on a regular basis. We also review all new care packages 72 hours following admission to the home".

People's views on the service had been sought by way of satisfaction surveys and resident meetings. The last

meeting was held in April 2017. People were supported to discuss and choose what activities they wanted to take place in the forthcoming months. Minutes showed people had requested particular meals and activities. The registered manager told us all actions would be met by the end of May 2017.

The provider had ensured people and their relatives were able to share their views and experience of the service. The result of the last customer satisfaction survey in December 2016 showed it had been completed by nine residents. 75% said they were overall happy with the service 100% felt listened to and 33% wanted more activities. The registered manager told us, "We have additional staff who will be supporting the activity programme, they are all very enthusiastic in supporting different interest, including gardening and trips out". One member of staff told us they were looking forward to working as part of the activity team. The service had received positive feedback from relatives who expressed satisfaction in the care people received.

The registered manager had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that of fire safety equipment took place.

The registered manager has notified the Care Quality Commission of all significant events and notifiable incidents in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care systems were not in place to ensure people received person centred care and treatment that was appropriate to meet their needs and reflect their personal preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure people were consulted in regards their care and treatment .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks, or to ensure risk remained as low as reasonably possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the service provided were not always effective in identifying shortfalls in the care and support provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff received appropriat4e on going and periodic supervision in their role to make sure compliance is maintained