Mellifont Abbey LLP

Mellifont Abbey

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 24 and 25 October 2017.

At the last inspection, on 6 and 7 December 2016 we found a number of concerns. This included people who lacked capacity who were not having decisions made in line with Mental Capacity Act 2005 (MCA), there was not enough staff and the registered manager was not maintaining the quality of the service. Other issues were found in relation to the safety of the service such as medicine management and risk assessments. As a result, we had asked the provider for an action plan. We added five conditions to their registration which meant they had to provide the commission with monthly updates. This inspection was brought forward following a number of concerns that had been raised with the Commission.

During this inspection we found there had been some improvements around the MCA, medicine management and staffing. This included better monitoring of staff levels and more specialist training for staff. Some risks to people had been identified with plans to mitigate them and some for the environment. The registered manager had also created some quality assurance tools to monitor the service. However risk assessments were not suitably comprehensive to take account of all relevant risk. Where fridge temperatures were not suitable there were no records of actions taken to rectify the problem to support effective monitoring. Legislation for medicines requiring additional storage had not always been followed. The registered person was not always identifying shortfalls in safety and quality at the service.

Mellifont Abbey can provide residential accommodation and personal care for up to 23 people. When we visited there were 20 people living at the home and one person in hospital. People at the home had a mental health needs , were living with dementia or both. As a result of this, some people had limited verbal communication. If people required nursing care the community nursing teams would visit.

A registered manager was in place to run the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The management structure included a service manager to support the registered manager. Prior to this inspection the service manager had just left. The registered manager was being supported by a deputy manager and supervisors.

The home was not well led and shortfalls identified during this inspection had not been identified by the registered person. There was a reactive approach from management and reliance on external bodies to identify issues at the home. The provider had not completed statutory notifications in line with legislation to inform external agencies of significant events. The provider's website was not displaying the current inspection rating for the service as required.

People were not always kept safe at the home because, for example, staff had not received training in pressure area care or procedures around monitoring blood sugar levels for people who needed this care.

There were risks of infections spreading because actions had not been taken when concerns were identified. Risk assessments were carried out to enable people to retain their independence and receive care with minimum risk to themselves or others. However not all risks had been identified so that staff had full guidance to follow.

The registered manager had developed positive relationships with people. People liked living at the home. There were some systems to monitor the quality of the service and some improvements had been made in accordance with people's changing needs.

Most medicines were managed safely and stored appropriately including those requiring additional security. People were protected from potential abuse because staff understood how to recognise signs of abuse and knew who to report it to. There were recruitment procedures in place to protect people from unsuitable staff.

Most people were supported to have choice and control over their lives and staff supported them in the least restrictive way possible. However, when people specified the gender of staff to support them with intimate care this had not always been respected. People who required special diets had their needs met and meal times were treated as a social opportunity. Staff had been trained in areas to have skills and knowledge required to effectively support people. People told us their healthcare needs were met and staff supported them to see other health professionals

Care and support was personalised to each person which ensured they were able to make choices about their day to day lives. Activity coordinators liaised with people about the activities they would like. However, the timetabled activities were not shared in the communal areas and some people did not feel their interests were met. Complaints were investigated and responded to by the registered person when guidance was provided by external parties. One complaint had no records to demonstrate it had been investigated following the provider's policy.

People and their relatives told us, and we observed, that staff were kind and patient. People's privacy and dignity was respected most of the time by staff. Their cultural or religious needs were valued. People, or their representatives, were involved in decisions about the care and support they received. People who had specific end of life wishes had their preferences respected by staff to help provide a dignified death.

We have found one breach in the Care Quality Commission (Registration) Regulations 2009 and two breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some people were put at risk because their current care plans lacked guidance for staff and risk assessments had not always identified actions to mitigate risks.

People could expect to receive their medicines as they had been prescribed. Some improvements were required for medicines requiring additional storage and maintaining correct medicine fridge temperatures.

People had risks of abuse or harm minimised because staff understood the correct processes to be followed.

People were protected from the risks associated with poor staff recruitment because a recruitment procedure was followed for new staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Most people were supported by staff who had the skills and knowledge to meet their needs. However, the provider had not identified specific training for staff, for example in pressure care.

Most people had decisions made in line with current national guidance.

People had access to medical and community healthcare support.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes.

Is the service caring?

Requires Improvement

The service was not always caring.

People's preference for the gender of staff to support them with intimate care was not always respected. Sometimes decisions

were made by staff without consulting people.

People's privacy and dignity were respected most of the time by staff.

People's needs were met by staff who were kind and caring. Staff respected people's individuality and spoke to them with respect.

People were able to exercise their religious and cultural beliefs. Visitors were welcome at any time, and people's routines were personalised to allow this.

People had a dignified death because staff respected their end of life wishes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs and wishes regarding their care were understood by staff. However, care plans lacked important information to provide guidance for staff.

People benefitted because staff made efforts to engage with people throughout the day. Activities were in place in accordance with people's interests. Some people were unaware what activities were available.

People knew how to raise concerns. However, complaints had not always been managed in line with the provider's policies and required input from external agencies.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager was not fulfilling their legal responsibilities because notifications were not being sent to the commission.

People were not living in a home which had clear external scrutiny to ensure they were receiving care and treatment in line with their needs.

People and their relatives were not always kept informed by the provider about recent inspections because their website did not display their ratings.

People benefitted from living in a home where there was a

staffing structure to provide lines of accountability.

Mellifont Abbey

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 inspection took place on 24 and 25 October 2017 and was unannounced. It was carried out by three adult social care 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 for people.

As this inspection was brought forward following concerns received the provider had not 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 provider's action plan, spoke with other health and social care professionals and looked at other information we held about the home before the inspection visit.

We spoke with 15 people that lived at the home, one relative and a health professional. We also had informal conversations with people at the home as we walked around and completed the inspection. We spoke with the registered manager, deputy manager and six members of staff including activities staff, kitchen staff and care staff. During the inspection, on the telephone we spoke with another member of staff. Before and following the inspection we spoke with two other social care professionals. 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 looked at four people's care records in depth and ten people's care records in relation to medicine management. We observed care and support in communal areas. We looked at three staff files, previous inspection reports, action plans received from the provider, staff rotas, quality assurance audits, staff training records, the complaints and complements files, medication files, environmental files, activity records, statement of purpose, provider internal communication documents and a selection of the provider's policies.

Following the inspection we asked for further information including provider policies, other documents relating to the service and actions taken by the registered manager. There were some delays in response to the time frame we asked for the information. The registered manager told us they had issues with their computer system.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found risks had not always been assessed to ensure the safety of people. As a result, a condition was added to the provider's registration to inform us monthly of actions taken to ensure all potential risks to people had been assessed regardless of the length of their planned stay. The monthly reports informed us they had reviewed the template used to record individual risks and assessed control measures in place. During this inspection we found people had some risks identified in their care plans. For example, one person's care plan said, "Can be unsteady on her feet and should be encouraged to mobilise with staff either holding her hands or behind her". During the inspection we saw this was happening. However, other risks had not been identified nor was there guidance for staff to follow. For example, discussions with a relative and staff identified this person would go to their bedroom independently up the stairs. There was no information for staff about how to support this person to continue this behaviour safely.

There was inconsistent guidance and risk assessments in place for people with specific health or care needs. For example, one person had been identified as having continence needs. There was no information in their care plan detailing the type of support staff should provide to meet their needs and keep them safe. The care plan contained a handwritten note "High chance of skin tears"; there was no information for staff to follow about how to support this person and reduce the risk of damage to their skin. On one occasion, in October 2017, it was recorded their skin had been torn at night by a member of staff.

Another person who lacked capacity had a risk assessment because they were at high risk of pressure damage to their skin. This did not clearly indicate what control measures needed to be in place to make sure staff were proactive in minimising risks. Nor did it state how many wounds the person had. The risk assessment stated they needed to wear heel protectors as they had pressure ulcers on both heels. One member of staff confirmed there were pressure ulcer on both heals. Their care plan stated they should be repositioned every two hours at night and records showed there was regular repositioning at night to alleviate pressure on their body. There was no information about the frequency of repositioning in the day. However, two members of staff we spoke with thought the person should be moved every four hours. This person spent much of the day sat in a wheelchair with a pressure relieving cushion and the repositioning chart did not show they had been helped to change position during the day. However, other information about how to reduce further risks was minimal. For example, the instructions and appropriate settings were not recorded for the pressure relieving mattress on their bed. The lack of clear guidance for staff to follow meant the person was at risk of not receiving the care required to promote their well-being and health. Following the inspection, we raised our concerns about this person's needs to the local authority who arranged for them to be reassessed.

One person had diabetes and their risk assessment lacked full information to enable staff to manage the associated risks. Their care plan informed staff to monitor the person's blood sugar level but it did not state what was an acceptable range for this person. Neither did it inform staff how to recognise if the person was unwell or what to do in specific situations related to their diabetes. This meant the person could potentially be at risk of their health declining and this not being recognised by staff. During the inspection the registered

manager told us staff were testing the person's blood sugar levels. No checks on the blood sugar machines were made to ensure they were accurately displaying readings. Staff had not received recent training or had competency checks completed to ensure this was being completed safely.

Care plans contained some information about people's behaviour but not all had sufficient detail to inform staff of the actions needed if people displayed behaviours that could be challenging to themselves or others. For example, one person's care plan said, "If [Name of person] starts to hit out staff are to let her cool down for a bit". However, there was no information about the triggers to this behaviour or further guidance for staff to follow. Other people lacked plans with enough details for staff to follow when a person became anxious or distressed. For example, one person had been involved in an incident where they had hit a lift door with force whilst another person was in it. This behaviour had not been risk assessed and no plan put in place to reduce the potential risk. This meant people were at risk of being hurt by others because staff did not have clear guidance to follow when a person became distressed.

At the last inspection there were not sufficient risk assessments in place and checks on the environment to ensure the building and grounds were safe for people living with mental health needs. As a result, a condition was added to the provider's registration to regularly inform us of actions taken to ensure risks in the environment had been assessed and checked. During this inspection we found there had been some improvements. People now had individual evacuation plans in the event of a fire which identified some of their needs. However, there was a lack of guidance to inform staff what type of support some required during an evacuation. For example, one person had an evacuation plan which identified they were fully mobile. It then stated the person could have difficulties standing. There was no further information about the actions staff should take in the event of a fire to support this person to stay safe. This meant although some risks to people in the event of a fire had been identified, no actions to mitigate them had been established to prevent harm. The environmental risk assessment had not identified concerns raised at the previous inspection around suicide prevention although some staff had received training. One person in the home had a history of attempted suicide. This meant the provider was not responding to all concerns previously raised to keep people safe.

People were not always kept safe because issues which could lead to infections spreading were not proactively resolved. The provider had identified an issue in August 2017 which could place a particular person, who lacked capacity, at risk of harm because of the environment they were living in. During the inspection the person became unwell and was still eating their lunch in this place. No meetings with other health and social care professionals had been held to discuss what was in the person's best interest in relation to their health.

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

At the last inspection we identified shortfalls in the number of staff available to meet people's needs. As a result, a condition was added to the provider's registration to inform us regularly of actions taken when staffing levels had been assessed in line with people's needs. reviewed. Since this inspection, the provider had told us they were now ensuring staff levels were "At the correct level for providing support for the various needs of the residents". They had been using a risk assessment to monitor when staff were required. During this inspection we found there were some improvements. People were being supported by enough staff to meet their needs. It was too early to identify whether this improvement was sustainable because there was a lack of assurance around monitoring of the changes. Call bells were being answered promptly. People told us, "There's always staff to ask if you want anything" and, "There's always someone here when you need them." People who spent time in their rooms had access to a call bell to enable them to summon

assistance if they required it. One person told us they had had a fall in their bedroom and had rung their bell for help. They said, "I rang the bell and they came very quickly."

The registered manager told us how many staff were required to safely support people. They explained staff levels were now risk assessed regularly and we saw this was happening. The registered manager had identified early to late evening was a time more staff were required. This was because people wanted to do activities and have time to talk. As a result, recruitment was underway to fill this additional staff need. One member of night staff commented that two staff were usually "ok" at night, but some nights were very busy. They said that when they needed two staff to support a person it left the communal areas without staff. They explained the introduction of the twilight shift had made a huge difference and it would be even better if the shift was until midnight rather than 10pm. The registered manager was also looking for volunteers to spend time with people whilst the care staff were meeting their daily needs.

However, some staff we spoke with had concerns about staffing levels in the home. One member of staff said, "We have enough staff to meet people's needs but no extra. Ideally we need one supervisor and three care staff in the morning." Another member of staff told us, "Everyone here cares but there's not enough time to care. I don't feel I do what I should be doing because I often have to take people to appointments and do teas." In the provider's monthly reports they still indicated a high turnover of staff which could lead to inconsistent care being delivered. The registered manager told us, "It is not easy to recruit here. Use agency staff when I need to."

At the last inspection the management of medicines was not safe, including administration at night. As a result, a condition was added to the provider's registration to inform us regularly of actions taken to ensure people's medicines were managed safely. During this inspection we found improvements had been made. It was not clear how sustainable these changes were because there was lack of assurance around monitoring. One person told us staff brought their medicines twice a day. Staff helped them rub cream into their legs, chest and arms. We saw medicines were administered in a safe and respectful way. People received their medicines within suitable timeframes. Care plans highlighted people's preferences for their medicines. All staff members who administered medicines had completed online training and been assessed as competent before being allowed to administer any. The registered manager was investigating further training and support from the local pharmacy.

Medicines stored securely and room temperatures were monitored daily. The registered manager had identified that the current rooms used to store medicines were not appropriate and were moving them imminently to a better location. This would improve the management of medicines and safety. A medicines refrigerator was available and records showed this was kept at a safe temperature for storing medicines. However, the temperatures had occasionally gone out of range. Staff told us these concerns were always reported to the registered manager and action taken. There were no records of these actions. This meant it was not clear if the integrity of the medicines in the fridge had been considered following a high temperature.

Suitable storage was available for medicines that needed additional security. Staff made regular checks of these medicines to make sure they were looked after safely. Each signing in or out of one of these medicines was countersigned. However, these registers were not always maintained correctly. For example, the balance of stock was correct for one medicine yet the entry was incompletely written. This meant they were not managing these medicines in line with current legislation.

People were protected from unsuitable staff supporting them because a recruitment process was in place for all prospective staff. The registered manager held interviews. Contact with previous employers was made

for references and a Disclosure and Barring Service (DBS) check was completed. A DBS check is to make sure staff are suitable to work with vulnerable people. However, one member of staff did not have a full employment history in line with current legislation. There were no dates in their application form for a previous place of work. The registered manager thought they had asked the dates; there was no record of this. During the inspection the registered manager spoke with this member of staff to resolve the issue.

People had some health and safety issues considered to keep them safe. For example, there were restrictors on windows to prevent them from opening too wide to prevent falls from heights. However, the home was not clean in places. Areas of the home were not being cleaned regularly because the systems were not being overseen. For example, we found one room with a musty odour and dirty floor. A second bedroom had a dirty floor with bits of fluff all over it. One member of staff told us there was no cleaning roster. The registered manager said, "Cleaning staff have their own schedules" and explained they monitor by "Going around". This meant there was a risk people's well-being being compromised.

People appeared comfortable and relaxed in their environment. People smiled and chatted to staff in a relaxed way. One person told us, "All the people who work here are very nice and very friendly." Another person told, "I feel safe because nothing is a problem." One relative said, "I am terribly happy with everything which is being done for Mum".

Risks of potential abuse to people were minimised because staff had received training about how to recognise and report abuse. One person told us they had not seen anything which had upset them. One member of staff said, "I would report directly to the supervisor or the deputy. I think something would be done." Another member of staff said, "I would report any abuse. I am sure something would be done." Staff who reported another member of staff said they had been nervous about reporting. They continued they felt very supported since they did raise concerns.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that people who lacked capacity were not having decisions made in line with current legislation. As a result, a condition was added to the provider's registration to inform us regularly of actions taken when people lacked capacity and decisions were made on their behalf. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

During this inspection we found most people who lacked capacity had decisions made on their behalf following the principles of the MCA. We found that people's ability to make specific decisions had been assessed and where they were found to lack capacity best interests decisions had been made. For example one person required a change in their sleeping arrangements when they returned from hospital and an assessment had identified they were unable to fully understand or consent to this. Therefore a best interest decision had been made. It was too early to identify whether this improvement was sustainable.

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. The provider had made applications for some people to be deprived of their liberty to keep them safe. There was a tracker form in place to show progress of each application.

However, people were not always having DoLS correctly applied for. For example, two people who had the capacity to consent about the restrictions being placed upon them still had DoLS applications. One of these people already had consented for their flu vaccination. Another person had verbally consented to their cigarettes being withheld to improve their health. This meant there was a lack of understanding by senior staff about when DoLS applications should be made.

Most people were supported by staff who had received training in health and safety and subjects relevant to their care and health needs. One member of staff commented, "The mental health training we did helped me to better understand people who live here." Others said, "Someone from the Huntingdon's Society did some training. I think I am better able to support people now. They were really knowledgeable and said we could contact them anytime." and, "I do get in house training. Suicide prevention, self-harm and manual handling". The provider had systems in place to track what training each member of staff had received and when they required training to be up dated. However, none of the staff had received training to meet people's needs when they had pressure related issues. This meant one person with a pressure ulcer did not have all their health needs met or understood by staff. We spoke with the registered manager who immediately started to organise relevant guidance and training for staff.

People said they had access to healthcare professionals to meet their individual needs. One person said, "If

anything was not right they phone the doctor." Another person told us staff assisted them to attend diabetic clinic appointments. One person had diabetes and discussions had occurred with their GP about their dietary choices to ensure it was safe. During the inspection we saw district nurses regularly visited people who required their support. On other occasions other health professionals such as physiotherapists and doctors had visited the home to meet people's health and care needs.

People were reasonably happy with the food provided at the home and said there were always choices. We saw at lunch time that food was well presented and looked nutritious. One person said, "The food is excellent. It is marvellous" and informed us they had choice. Other people's comments about food included; "Food is very good, not top notch but plenty of variety," "Food is very nice" and "Food here is good, always plenty to eat." One relative said their family member, "Eats well" and went on to say "They [meaning the staff] give her [meaning their family member] at least three biscuits" at snack time. People's dietary requirements were understood and met by the kitchen staff. One member of staff explained they spent time checking labels because one person had a lactose intolerance.

People's care plans informed staff about their likes and dislikes around food. This was important because some people lacked the ability to remember or verbally communicate these to new staff or agency staff. For example, one person's care plan informed staff their likes were bananas, cups of tea and ice cream whilst they disliked curries and spicy foods. Another person's care plan said they "Enjoys roast chicken and eggs". Staff recognised when people started to lose weight and sought guidance to ensure the person maintained their health. For example, one person who had been recognised as not eating well was on additional nutritional drinks.

Requires Improvement

Is the service caring?

Our findings

People were offered choice and most of the time this was respected. For example, one person was asked if they wanted a dressing gown on whilst sitting in the dining room. The person said, "No. I'm boiling". In response the member of staff placed the person's dressing gown next to them on a chair so they could use it later. Another person was still in bed late in the morning. They told us they had a restless sleep due to a health condition. It was clearly their choice to remain in bed and they told us staff had listened to their wish.

However, people's preference for the gender of staff to support them with intimate care was not always respected. One person's care plan stated they preferred female support. There were four nights in a three week period when only male staff had worked. The person's care plan said they would need support with intimate care during this period. This was confirmed by members of staff. The registered manager explained the agency had been sending male staff because no one had informed them female staff were specifically required. They told us they would speak with the agencies. On another occasion, we observed music was changed in the dining room by a member of staff who did not consult with people about their preference. One small lounge had a large television which was on very loud and no one appeared to be watching it. One person said, "One thing that gets on my nerves is the cowboy films. I suppose the men like them though." There were no men in the lounge at the time. This meant people's preferences were not always checked by staff. Following the inspection the registered manager told us one person who stayed in the lounge a lot liked to watch cowboy films.

People were supported by staff who were kind and caring. People were complimentary about the staff who supported them. People told us, "Staff are always kind." and, "I've got dementia, it's very frustrating. I can't go out on my own but the staff are very understanding and very helpful." One person told us how kind and caring the staff were. They explained when they moved bedrooms in the home a member of maintenance staff helped them carry all their belongings from the old room to the new one in a laundry basket. They continued the staff member then hung their tapestries back on the wall. One relative said, "I am terribly happy with everything which is being done for mum". One health professional told us, "Staff do try very hard" when they were describing the support people received.

Feedback forms completed by people and their visitors reflected the positive things which we were told about staff. For example, one said, "This place and the staff are lovely". Whilst others read, "This is a wonderful, caring facility", "Very welcoming. Thanks everyone" and "Very friendly staff and lovely atmosphere". During the inspection, we saw staff interacting with people in a friendly respectful manner. Some people shared a joke with staff and there was some friendly banter. One person commented, "It's all very relaxed and comfortable."

People's important events were respected by the staff and registered manager. For example, two people living at the home were celebrating a significant wedding anniversary. Television crews had been invited to the home to record their achievement. During the inspection the registered manager showed us this news story. We saw the married couple were able to spend time with each other daily. One relative spoke with us about their family member who had a significant birthday celebrated. They explained their family member,

"Had a lovely hundredth birthday".

People's privacy was respected and all personal care was provided in private. When people required support with intimate care they took people to their bedrooms or a bathroom. One person told us, "I never thought I'd need help and I never thought I would get in a shower. But the lady who helps me is so very kind and respectful." Another person said, "Couldn't meet more courteous people [meaning the staff]" when they received support from them. People were well dressed and clean showing staff took time to assist people with intimate care.

People told us and we saw they were able to have visitors at any time. Each person who lived at the home had a bedroom where they were able to see personal or professional visitors in private. We saw some visitors met their relatives in communal areas whilst others went to their bedroom. One person said, "We're allowed visitors, they have to sign a visitor's book". Other people explained their relatives come to visit them regularly.

People had their end of life needs and wishes considered. Some people had detailed instructions for staff to follow. For example, one person's plan said, "[Name of person] would like to be cremated and have a service in [Name of church] first". There were further details about a family member playing the organ during the service.

People had their cultural or religious preferences respected. One member of staff explained most people followed the Church of England. They recollected a spiritualist who had lived at the home in the past. The person had access to vegetarian food in line with their beliefs. Another person required support from only female staff due to previous distressing life experiences. The member of staff knew this and respected the person's preference.

Requires Improvement

Is the service responsive?

Our findings

People were able to follow their own routines and please themselves how they spent their time. One person told us, "You can do what you like really. I spend time in my room and get the paper delivered every day so that keeps me busy. I watch a lot of sport on the telly." Another person said, "We have times for meals but that's about it. I usually go to bed between nine and ten but it depends what's going on."

Some people were able to take part in activities according to their interests. One person pointed to one of the activity co-ordinators and said, "They get all the games going and take people out." We saw one person sitting knitting and one person was reading. There were two activity co-ordinators who arranged activities and events. Some people accessed local facilities to help them to remain part of the community. For example, during the inspection we saw two people go to a knitting club. The registered manager told us people would go to Tai Chi. They also explained there were day trips arranged for people to attend.

However, activities planned were not prominently displayed which meant people would not know what was going on to enable them to plan their time around things that interested them. One person told us, "I used to play football, I like sport. There aren't many opportunities to go out. There's not much going on that I know of." Another person said, "Don't go out on my own which is very upsetting, can't always get someone [meaning staff] to go, that's the worst part. That's why I go up and down the stairs, I'm used to walking. Not often that I can go out for a walk and someone [meaning staff] be available." One activity co-ordinator explained that because of staff shortages in the home they did not feel they had enough time to plan and support people with activities. They also told us they did not have a space where they could make phone calls and email people to arrange activities.

People had their needs assessed and everyone had a care plan which gave basic information about how people liked to be assisted. There were pen portraits which provided a brief overview to help staff new to the home or agency staff. For example, one person's portrait said, "I have a lovely singing voice to sing hymns" and "Time being taken to make me feel comfortable. I may not be happy with the process but I am happy with the end result". During the inspection they were singing in the dining room and staff were patient when helping them to walk round the home. Another pen portrait said the person enjoyed, "Looking nice and dressing nicely". We saw they looked well dressed and clean.

People's care plans contained some information about their communication needs. This was important for those with illnesses like dementia who could struggle with verbal communication. For example, one person's care plan said, "[Name of person] will reply to questions around choices". One person was proud of the life history they had completed with a member of staff. They told us to look at it because they did not want to talk about it again. It recorded important events and people in their life. This included their wedding and their family members. They pointed at the picture from their wedding and smiled with fond memories.

Care plans lacked specific guidance and details in order for staff to ensure people's health and care needs were being met. They did not give information about people's personal routines. This meant that people who were unable to fully express their wishes may not receive care in accordance with their preferences.

Although staff we spoke with during the inspection knew people well the home also used agency staff who would not have knowledge of people's preferences.

There was a complaints system in place which clearly outlined how people could raise their concerns. People and relatives told us they would speak with a member of staff. One person told us, "Always go to lady who owns place" when they had a complaint. They agreed it was always resolved. Another person said, "Feel people who work here are so easy to talk to." There was an ongoing complaint being investigated by senior staff. The registered manager had been supported by the local authority with how to manage the complaint. However, one complaint which had been made in August 2017 had no records about the nature of the complaint and actions which were taken in response. This meant the provider was not always following their own complaints procedure.

People were kept informed about news which had occurred and events which were planned through the home's newsletter. For example, the summer edition included information about the next cream tea event. There were photographs of people participating in activities at the home. Other information was passed on about the ongoing decorating in the home so people were aware of what the maintenance team were doing. People were informed about their options when there was a takeaway night and the food choices on offer.

Inadequate

Is the service well-led?

Our findings

The service was not well led. The registered manager was the controlling person for the provider. There was no external scrutiny. This meant there was a lack of assurance around the monitoring and sustainability of the home. The last inspection at the home was in December 2016. However, the registered manager had begun some changes including the senior handover auditing system at the end of August 2017. During this inspection the registered manager shared another quality assurance system they were creating. They told us it was going to be introduced the week after the inspection. They explained it had not yet been used because they had been working on it for months.

This was the third inspection the home had been rated requires improvement overall. At the last two inspections we identified shortfalls in the management and monitoring of the quality and safety of the service. This included how they were remaining up to date with current regulations and guidance. As a result, five conditions were added to the provider's registration. These were statutory requirements in place to drive improvements in the home in areas of concern found at the last inspection. The registered person submitted an action plan to outline how they were going to make the necessary improvements. Monthly reports were received by the commission to outline the provider's actions taken as a result of various audits being completed and how the action plan was being met. These were all reviewed during this inspection.

There had been improvements in some areas relating to the registration conditions and action plan. For example, most people who lacked capacity had action taken in line with current statutory guidance. There were some risk assessments in place for individuals and the environment. Staff levels were now being monitored by the registered manager. This meant issues which had been brought to their attention had some actions taken to address them. On other occasions the local authority had visited to drive improvement. As a result of these visits the content of care plans and audits were being amended.

The registered manager was striving to improve the home. They told us, "I want to make changes to continually improve the service". There were occasions when the new auditing systems had identified improvements were required. For example, after reviewing the senior staff handover a person's health had declined so a review with health professionals was arranged which identified a health issue. However, the systems in place for monitoring people's care did not appear to adequately identify shortfalls we identified at this inspection. For example, the lack of detail in risk assessments and associated care records and ensuring people's preferences were followed.

The registered manager continued to demonstrate they were not keeping up to date with current guidance. For example, notifications were not being sent in line with statutory requirements. Neither did the statement of purpose include the range of people using the home. For example, it said all people were over 60; they were not. This meant the registered manager was not ensuring the home was running in line with statutory requirements.

At the last inspection, the provider had not been displaying ratings of previous inspections at the home or their website. This meant people were not always being kept informed about recent CQC inspections at the

home. During this inspection we found ratings were now displayed in the entrance hall to the home but not on their website as required. This meant people and their relatives searching for the home online were not able to see the current inspection ratings for the home. Following the inspection and further communication from the commission the registered manager ensured their ratings were displayed.

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

The registered manager had not ensured notifications had been sent to the Care Quality Commission (CQC) of all significant events which had occurred in line with their statutory responsibilities. For example, there was a person with a pressure related wound which the registered manager had not informed us about. The registered manager agreed there should have been a notification. We had not been notified about 15 safeguarding referrals the local authority had been informed about since January 2017. Two DoLS had been authorised recently yet the provider had not informed the commission. This meant people's safety and care could not be monitored. We spoke with the registered manager who told us this could have been due to some senior staff changes which had occurred throughout the year. The registered manager had not identified the issues in their own auditing systems. They informed us they would now ensure all significant events were correctly notified to CQC. Following the inspection the provider sent notifications in relation to the concerns.

This is a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People told us they liked living at the home and the registered manager had developed positive relationships with them. One person said, "It's very nice. The lady that runs it is very nice." Two people became anxious and upset during the inspection. On both occasions the registered manager identified this immediately and went to comfort them with success. One of them told us the home was "lovely".

There was a relaxed atmosphere in the home and staff told us they were very happy in their work. Comments included; "I love it here. It's really homely," "I enjoy my job very much" and "When I've been off work I've really missed it. The people here are wonderful." The registered manager told us it was "Not a regimental home. More personalised". During the inspection we saw people moving around the home as they pleased and some were able to access the local community independently.

Staff understood the registered manager was responsible for running the home. They were supported by the deputy manager. Until recently, there had been a service manager employed to help as well. Supervisors led shifts and care staff supported them. The registered manager and deputy manager would help deliver care and support to people when they saw it was required. One member of staff said, "[Name of registered manager] has worked on floor when needed." Another staff member told us, "[Name of deputy manager] helps to support people, especially in the morning." This meant staff were clear about the lines of accountability in the home.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC without delay of significant incidents. Regulations 18 (1) (2) (e)