

Croftwood Care UK Limited

Ingersley Court Residential Care Home

Inspection report

Ingersley Court, Lowther Street
Off Church Street, Bollington
Macclesfield
Cheshire
SK10 5QA

Tel: 01625574233

Website: www.minstercaregroup.co.uk

Date of inspection visit:
12 November 2018

Date of publication:
31 December 2018

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 12 November 2018 and was unannounced.

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

The care home provides residential care to up to 46 people. During the inspection, there were 31 people living in the home, some of whom were living with dementia.

The previous registered manager had left the service and a new manager had been appointed and had been in post for seven weeks at the time of the inspection. 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. Feedback regarding the management of the service was positive and people told us they felt the service was improving.

The environment was not always safely maintained. Several safety issues were identified during the inspection, such as blocked fire exits which meant people would find it difficult to escape in the event of a fire and there were a number of items that people had access to that had the potential to cause them injury. We spoke with the manager about these issues and they were rectified during the inspection. Other safety issues could not be resolved on the day, such as risk of falls from a raised patio area that had insufficient security to prevent people from falling over them. However, following the inspection the manager confirmed these had been addressed.

People's risks in the delivery of care had been assessed, but these assessments were not always accurate or reviewed regularly. This meant staff may not have accurate information about how to support people safely.

We looked at how medicines were managed within the home and found that safe medicine practices were not always adhered to. For example, the booking in and recording of medicines was not always accurate and the temperature at which medication was stored was not always monitored consistently to ensure medicines were stored at safe temperatures. Records showed that the manager had made some improvements to the management of medication within the home over the past few months and audits showed that less issues were being identified as a result of this.

We found that there were not always enough staff on duty to meet people's needs in a timely way, especially at night. The provider acted on this straight away and increased the number of staff on duty at night and agreed to review the required number of staff during the day. Staff and people living in the home agreed that there were not always enough staff available.

Care plans were not always reviewed regularly and did not always reflect people's current needs. This meant staff did not always have access to information on how best to support people.

Systems in place to monitor the quality and safety of the service were not always effective. The manager undertook a range of checks on the service but the checks undertaken had not picked up on all the concerns we identified during the inspection.

Records showed that safeguarding incidents had been referred to the local authority safeguarding team appropriately. However, CQC had not been notified of these issues. This meant the provider failed in their legal duty to keep CQC informed of issues that may have had an impact on the quality and safety of the care people received

Staff told us they always asked for people's consent before providing care and when people were unable to provide consent, mental capacity assessments had been completed. These assessments were not always clear as to what decision needed to be made or who had been involved in best interest decisions. This meant people's consent was not always clearly recorded. We have made a recommendation regarding this in the main body of the report.

People told us they felt safe living in Ingersley Court. Staff were knowledgeable about safeguarding and whistleblowing and knew how to raise any concerns they had in line with their organisational policy and procedures.

Most safe staff recruitment practices were evidenced within the staff records we viewed. However, not all staff files provided a full employment history and the manager agreed to review these records to ensure they contained the required information.

People were supported by the staff and external health and social care professionals to maintain their health and wellbeing. People and their relatives felt that health needs were being met and that action was taken in a timely way when people became unwell.

Staff were supported in their role through an induction and supervision sessions. Regular training was available and records showed that most staff had completed the training the provider considered necessary to meet people's needs and provide good care.

Staff were familiar with people's dietary needs and we saw that these were met. People told us they enjoyed the food available, had enough to eat and drink and always had a choice of meal.

People told us that staff were kind and caring and treated them with respect and their relatives agreed with this. We saw people's dignity was protected by staff when they provided support and the people we spoke with confirmed this. People were able to be as independent as they wanted to be and had a choice regarding their daily routines and how they spent their time each day.

People's friends and relatives visited during the inspection and they told us they could visit at any time and were always made welcome.

Care plans included information regarding people's preferences, enabling staff to get to know people as individuals and provide support based on people's preferences.

An activity coordinator was employed by the provider and a range of activities were planned each month for

people to enjoy. People told us they enjoyed these activities available but said they would enjoy more opportunities to go out into the community.

People had access to a complaints procedure and told us they knew what to do if they had any concerns about the service or the care they received. The manager's records showed that any complaints received had been investigated and responded to appropriately.

Regular staff and resident's meetings took place to gather feedback from people regarding the service and we saw that the manager had taken action to improve the service based on the feedback received.

You can see what action we told the provider to take at the back of the full version of this 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.

The environment was not always safely maintained. People's risks had been assessed, but these assessments were not always accurate or reviewed regularly.

Safe medicine practices were not always adhered to.

There were not always enough staff on duty to meet people's needs in a timely way, especially at night.

People told us they felt safe living in Ingersley Court. Staff were knowledgeable about safeguarding and whistleblowing and knew how to raise any concerns they had.

Is the service effective?

Good 

The service was effective.

Mental capacity assessments did not always clearly reflect what decision needed to be made.

People were supported by staff and external health and social care professionals to maintain their health and wellbeing.

Staff were supported in their role through an induction and supervision sessions. Regular training was available and records showed that most staff had completed sufficient training.

Staff were familiar with people's dietary needs and we saw that these were met.

Is the service caring?

Good 

The service was caring.

People told us staff were kind and caring and treated them with respect.

People's dignity was protected in the delivery of care and people were able to be as independent as they wanted to be.

Friends and relatives were made welcome when they visited. For people who did not have friends or family to support them, the manager supported people to access advocacy services.

Is the service responsive?

The service was not always responsive.

Care plans were not always reviewed regularly and did not always reflect people's current needs.

A range of activities were planned each month and people told us they enjoyed them.

People had access to a complaints procedure and told us they knew how to raise any concerns they had about their care or the service.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not always effective.

CQC had not been notified of all required incidents, such as safeguarding referrals. This meant the provider had not fulfilled their legal responsibility to do so.

People's feedback was sought on the quality of the care provided and we saw that improvements had been made to the service as a result of this.

Requires Improvement ●

Ingersley Court Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 November 2018 and was unannounced. The inspection team included an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service to gain their views. They had no concerns.

The provider had 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 any improvements they plan to make.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the manager, area manager and five other members of staff. We also spoke with four people who lived in the home and three relatives.

We looked at the care files of three people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various times during the inspection.

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

Is the service safe?

Our findings

People told us they felt safe living in Ingersley Court. One person told us, "I definitely feel safe here" and all relatives we spoke with agreed. Relatives told us they were convinced their family members were safe and well cared for and that this reassured them when they left and went home. One relative said, "[Staff] definitely take safety issues seriously and will update relatives at the earliest opportunity."

We found however, that the environment was not always maintained to ensure people's safety. We observed a number of concerns around the home, such as a blocked fire exit, scissors and kettles accessible to vulnerable people, a door that did not close in the frame and a bedroom door that was wedged open. There was also a bin in the smoking area that was full of cigarette ends as well as tissues, which posed a fire risk. These concerns were raised with the manager straight away and were rectified by the end of the inspection.

Other safety concerns could not be resolved on the day. For instance, there was a leak in a bathroom ceiling, posing a risk of slips if the floor became wet. The manager agreed to lock the bathroom until the leak could be repaired. The lounge windows contained blinds that were broken and did not close fully. They did not provide any privacy to people sitting in the lounge, which faced the road in front of the home. We also saw a raised outdoor patio area that was used as a smoking and posed a risk of fall from height. We asked the manager how this risk would be managed to ensure people remained safe and following the inspection, they confirmed that fencing had been installed to mitigate this risk.

Staff had assessed people's risks with regards to falls, malnutrition, moving and handling and skin integrity. We found however, that these assessments were not always reviewed regularly to ensure they were up to date and accurate. One person's risk assessments had not been reviewed for two months and their health and care needs had changed during that time. Another person's file showed that when they had been weighed two months ago, they had lost some weight. However, they had not been weighed since, despite their plan stating they should have their weight monitored monthly. There was a risk they could have lost further weight that had not been identified.

People had a personal emergency evacuation plan in their individual care files. We found however, that there was no grab file or copy of the plans available for people to access quickly in the event of an emergency to assist with people's evacuation. The manager told us they would create an emergency file straight away.

We looked at how medicines were managed within the home. The manager told us there had been a number of medicine errors identified recently and they had been working to make improvements in how medicines were managed. A range of new medicine audits had been created and were completed daily, weekly or monthly to monitor the safety of medicine administration. These audits showed that the number of issues identified had reduced over the past few weeks as the home's medication systems had been improved upon.

We found that not all safe administration practices were adhered to. For example, medicine administration

records (MARs) showed that not all medicines had been booked in accurately, so we were unable to check the stock balance of these medicines. Another person who required a medicine to be administered to them on a PRN (as and when required) basis, did not have a protocol in place to inform staff when they required this. This meant they may not receive it in a consistent way, or when they needed it.

Staff had access to a medicine policy to guide them in their role and all staff who administered medicines, had completed training and had their competency assessed. People living in the home did not have any concerns about how their medicines were managed. Systems were in place to support staff to administer medicines safely and as prescribed. For instance, one person who required a patch to be applied to a different site on their body every few days, had a body map in use to allow staff to record where the patch had previously been applied to prevent the same site being used.

Medicines need to be stored within safe temperature ranges to ensure that they work effectively. Records did not reflect that medicines were always stored within these safe ranges. For instance, the room temperatures were regularly recorded as above the safe temperature range with only one day indicating that any action had been taken to address this. Minimum and maximum fridge temperatures were recorded and these were both outside of the recommended temperatures, although the actual temperature of the fridge on the day of inspection, was within the safe range. This meant there was a risk that some medicines may not work effectively.

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

We looked at how the home was staffed and found that there were not always enough staff on duty to meet people's needs in a timely way. On the day of the inspection there was one care team leader and three carers on duty, along with domestic and catering staff, supporting 31 people living in the home. Six people required the support of two staff members and the building was large and based over two floors. This made it difficult for the four care staff on duty to meet people's needs in a timely manner. We observed staff to be very busy throughout the day. We observed one person had to wait ten minutes for a second staff member to be available to support them to transfer.

Overnight there was one care team leader and two carers. The care team leader administered medicines in the evening and early morning, leaving only two care staff to support people. As several people required the support of two staff, this meant that there would be times when no staff would be available to respond to people's requests for support. We discussed this with the manager and area manager, who spoke with the registered provider and agreed to increase the number of staff on duty at night straight away.

People living in the home told us, "There are not always enough staff on duty", "Staff have never not helped, it is just that sometimes it is all a bit slow", "They don't seem to have enough staff, particularly when they are busy with toilet runs" and "There are occasions when I think there are not enough staff around, particularly if one person is off sick." Relatives we spoke with agreed and said, "There are occasions at the weekend when I think staffing numbers are too low", "Usually it looks like they can cope, but it doesn't take much for you to think that more staff is required", "I don't think they have enough to cope with the demands and every member of staff seems to be rushing around all the time" and "I really don't know how they manage with so much to do and such small numbers on duty."

Staff also told us there were not enough staff on duty and were genuinely concerned that this was impacting on performance, especially their ability to complete records and review care plans. A staff member told us they were often running between people and prioritising their needs. The manager told us they would

review people's level of dependency the next day and adjust staffing levels accordingly.

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

Staff we spoke with were knowledgeable about safeguarding and whistleblowing procedures and knew how to raise any concerns they had in line with their organisational policy and procedures. The manager maintained a log of all safeguarding incidents and this was reviewed and updated each month. Records showed that safeguarding referrals were made to the local authority appropriately for investigation and records were kept of the outcomes of these investigations. This helped to ensure that appropriate actions were taken to protect people from the risk of abuse.

There was a clear equality and diversity policy in place and staff were all aware of this. This policy helped to raise staff awareness of how to ensure people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010.

We looked at how staff were recruited within the home. Staff files contained evidence of photographic identification, appropriate previous employer references and Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We found however, that not all of the staff files we looked at contained robust information regarding the previous employment of staff. The manager assured us they would review these records and ensure they were updated to reflect the required information.

We looked around the home and found it to be clean. The housekeeping team had a cleaning schedule to follow to ensure the home remained clean and odour free. There was an infection control policy in place and bathrooms contained liquid soap and paper towels in line with infection control guidance. Staff had access to personal protective equipment such as gloves and aprons and we saw these were used appropriately throughout the inspection. This helped to prevent the spread of infection.

Accident and incidents were recorded and reported appropriately. A monthly falls analysis was completed. This looked at how and why accidents and incidents occurred to help staff learn from and prevent them occurring in the future. which looked for any trends to try and help prevent future potential accidents. For example, following a fall, one person was provided with an additional call button, as well as a sensor mat to help alert staff to when they mobilised so that staff assistance could be provided in a timely manner to prevent a fall.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). There were no authorised DoLS in place for any of the people living at the home at the time of our inspection. Records showed that ten applications had been made to the local authority by the manager in order to deprive people of their liberty and were pending approval. One renewal application had also been made as the authorisation had expired. The manager had created a tracker to help ensure they knew where each DoLS application was up to, but we found the manager's tracker was not completely accurate. This was because one person was not included in the list, but had a DoLS application within their care file.

Records showed that staff had received training regarding the MCA and those we spoke with had a good understanding. Staff told us they always asked for people's consent before providing care and people living in the home confirmed this. We saw staff asking permission before assisting people at lunch time and when supporting people to mobilise.

Where people's capacity to consent was in question we saw that mental capacity assessments had been completed with regards to this. We found however, that these assessments were not always clear as to what decision needed to be made. For instance, one capacity assessment referred within the decision to falls, medicines, dangers and other areas of care. This meant that the assessment was not decision specific. We also saw that best interest decisions, completed when people lacked capacity, did not clearly reflect who had been involved in the decision made and just stated family and staff. We spoke to the manager about this and they agreed to review how consent was sought and recorded straight away.

We recommend the provider reviews and updates records to ensure consent is sought and recorded in line with the principles of the Mental Capacity Act 2005.

Care plans we viewed showed that people's needs were assessed holistically. Care files included plans in areas such as people's physical, emotional and social needs. Pre-admission assessments showed that people's needs were assessed prior to them moving into the home. This helped to ensure staff knew people's needs and could meet them from the day they moved in.

We saw that equipment was provided to people in order to ensure they received effective care and support. This included the use of hoists, wheelchairs and bathing equipment. We saw that two people were provided with yellow crockery at meal times and told this was because they had visual impairment and the colour

helped people identify foods more clearly. This was good practice.

People at the home were supported by the staff and external health and social care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant professionals, such as the GP, district nurses, optician and social workers.

People and their relatives felt that health needs were met and the relatives told us they were kept informed of any changes to their family member's health. The comments made by people's relatives included, "Staff here have shown that they will respond quickly to the needs of [relative]" and "[Relative] needs more and more help and I am very confident that I will be kept up to speed with any developments as soon as practically possible."

We looked at staff personnel files. We saw that new staff received an induction into their job role in line with the principles of the Care Certificate. The Care Certificate is the government's recommended training for new staff. Staff also told us they completed training and shadowed other staff when they first started in post, until they became familiar with people's needs and the care they required.

Staff told us they felt well supported. Records showed that most staff received supervision every few months. Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. The manager had also scheduled in an appraisal of the skills and abilities of all staff members in the coming weeks.

We looked at ongoing staff training and support. Records showed us and staff confirmed, that most staff had completed training in areas such as moving and handling, fire safety, food hygiene, data protection, infection control, mental capacity, safeguarding and safe management of chemicals. Further training was required in areas such as health and safety and the manager was aware of this. Staff felt they had received sufficient training to enable them to support people safely.

People told us they felt staff were knowledgeable about their support needs. Both the people we spoke with and their relatives were confident staff knew what they were doing in the provision of care.

We looked at how people's nutritional needs were met. Care files included information regarding people's dietary requirements, such as whether they had diabetes, required a low salt diet, or needed assistance from staff to eat. The staff we spoke with were knowledgeable about people's dietary needs. We saw that if there were concerns regarding a person's intake, diet and fluid charts were maintained to ensure staff knew if they had eaten and drank sufficient amounts.

We observed lunch and found that people had a choice as to where they ate their meals and had a choice of meal at both lunch and tea times. People told us they enjoyed the food available. Their comments included, "I like having choices where I pick what I want to eat", "The new chef seems to be good", "I like meal times", "Portions are more than enough and the food is tasty" and "Drinks are always available and I like that with my meal." Relatives agreed and told us, "The food is delicious", "The food is always very good", "Excellent food and very nutritious" and "I enjoy a biscuit with a cup of tea when I visit."

The home contained wide corridors that were well lit and had handrails in place to support people. Call bells were available in people's rooms and adaptations had been made to some bathrooms to enable them to be used by people who required assistance to access them. Bedrooms contained personal belongings brought in from people's previous homes and reflected them as individuals. We found however, that further adaptations could be made to ensure the environment was suitable for all people living in the home,

including those living with dementia.

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. Their comments included, "The staff are marvellous", "If you need them, the staff just seem to be there", "I know I can rely on carers to help me", "All staff treat me well, but I do have my favourites", "It is good here, I am so well looked after", "No effort is spared in helping me when I need it", "All the staff are kind to us", "The carers are great, we have a right laugh" and "Staff are very friendly and approachable, I like that."

Relatives agreed that staff treated their relatives well. They told us, "The level of care shown to my relative is very good", "The care shown to my [relative] over a very long period has been excellent", "My family are so grateful to staff for the considerable and consistently high level of care displayed", "The staff really do their very best to look after my [relative]", "My [relative] depends a lot on the staff helping them and they don't let her down" and "I can't praise the staff enough, they love my [relative]."

All people we spoke with felt that they were treated with dignity and respect in the home. They told us all staff members knocked on their bedroom doors before entering and waited to be invited in and we observed this during the inspection. We also saw that staff intervened quickly to provide personal care when this was required and this type of care was always provided in private. People were given plenty of time and not rushed, such as during meal times, or when being supported to transfer. Care plans promoted respect and reminded staff to always be patient.

Care files were stored securely in order to maintain people's confidentiality in line with the Data Protection Act.

Interactions between staff and people living in the home were warm and friendly and it was clear that staff knew the people they supported well. We heard people called by their preferred name and care plans reflected whether people had a preference as to the gender of carer who provide their personal care.

People told us they were able to be as independent as they wanted to be and records reflected this. There were care plans in place regarding independence and these reminded staff to encourage people to do as much as they could for themselves. This was also reflected in the statement of purpose, where people's rights were recorded, one of which was independence. This stated that people would be encouraged to take "Thought out risks."

Staff told us that people had choice as to how they spent their time in the home and we saw examples of this during the inspection. Staff told us and people agreed, that they could get up when they chose to of a morning and go to bed at whatever time they chose. People had choice regarding meals, activities they could participate in and where in the home they spent their time.

We looked at the service user guide and statement of purpose which were on display within the home. These contained information about the service and what could be expected when a person moved in. It also included information regarding the complaints and safeguarding processes. This showed that people were

given information and explanations regarding the service which assisted with decision making.

We saw friends and relatives visiting during the inspection and they told us they could visit at any time and were always made welcome. They told us, "It's great that family and friends can visit anytime" and "We are always made welcome and we know we will be updated if any news has to be passed on." The manager told us that there were no restrictions as to when people could visit and this encouraged people to maintain relationships they had built in the community before moving into the home.

For people who did not have friends or family to support them, the manager told us they would assist people to access advocacy services when needed. Records showed that when people were receiving support from an advocate, they were involved in care file reviews and their views recorded. An advocate is a person that helps an individual to express their views and wishes and help them stand up for their rights.

Is the service responsive?

Our findings

Care plans were in place in areas such as medicines, sleeping, skin, personal care, religious needs, communication and mobility. We saw that people's care plans contained information that was specific to the individual. However, we found that they were not always kept updated or reflective of people's needs. One person's file reflected that they were mobile and could access the toilet independently. However, since the care plan had been put into place their physical condition had deteriorated and they were now immobile. The change in this person's physical condition and change in need had not been updated in their care plan, but staff were aware of the person's needs.

We also found that some people did not have care plans in place for all of their identified needs. For example, one person had diabetes, required a specific diet and regular health monitoring due to this. However, there was no care plan in place regarding this.

This meant that staff did not always have access to up to date information regarding people's needs, to ensure people received the support they needed. The manager told us they were aware that care plans required updating and it was on their action plan to complete.

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

Care files included a 'This is me' document which provided information regarding people's family members, things that were important to them, previous jobs, hobbies and holidays, religious needs, meal preferences and home lives. Care plans provided additional information regarding people's preferred daily routines and activities. This enabled staff to get to know people as individuals, understand their backgrounds and provide support based on their needs and preferences.

The manager told us there was nobody living in the home at the time of the inspection that had any specific cultural needs. However, the service demonstrated that they embraced people's beliefs and differences. For example, the statement of purpose stated that staff would "Positively communicate to service users that their diverse backgrounds enhance the life of the home."

The service was meeting the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to ensure that people with disability or sensory loss are provided with information in a format that they can understand. Assessments were completed and care files reflected if people had any visual or hearing impairment and how this would be managed to ensure people could communicate effectively.

People living in the home and their relatives told us that they were aware of the care plans in place and were actively involved in discussions regarding care. Relatives told us they were always kept informed of any changes by staff and staff told us they were made aware of any changes through daily handovers.

An activity coordinator was employed in the service and we saw a schedule of planned activities for

November 2018. These included a church service, biscuit and cake making, crosswords, singalongs, poetry, remembrance activities, dominoes, flower arranging, what's in the news, nail therapy, guess who, reading group, quiz, knitting, cards and bingo. The home does not have access to a vehicle to people on visits within the community and people and their relatives told us they would enjoy this.

People told us they enjoyed the activities available. Their comments included, "I like going to activities, particularly knitting", "Quiz night is great fun" and "When a lot of us get together, it can be fun."

There was a complaints procedure in place and this was displayed on notice boards within the home, as well as being included in the service user guide for people to refer to. People we spoke with were aware of the process and told us they would not hesitate to raise a concern if they needed to, but the need had not arisen. The manager maintained a complaints log and this showed that two complaints had been received since the last inspection. Records showed that these had been investigated and responded to in line with the policy and procedure in place.

Care files showed that when appropriate, people had been involved in discussions regarding their end of life care. Do not attempt cardiopulmonary resuscitation orders seen in some care files, had been completed with the input of relevant people. Files included people's preferences regarding care at the end of their life, such as their preferred place of care and whether they wanted to be admitted to hospital.

Records showed that staff worked with other health professionals to ensure people received safe and effective care at the end of their lives. The manager told us they also supported people's relatives during these times and provided space for them to be able to stay with their relative if they chose to. One relative shared their experience of how staff had supported them and made efforts to ensure people were comfortable and peaceful. They told us staff ensured the person's favourite music played in their room and that staff really did care for their relative. They said, "The approach of care team leaders and other staff members to the 'end of life' issue, cannot be faulted."

Is the service well-led?

Our findings

We looked to see how the registered provider and manager ensured the quality and safety of the service. Several audits had been completed in areas such as mealtime experiences, finances, laundry, kitchen and daily walk-rounds. We saw that some issues had been highlighted and addressed, but others had not. For instance, the infection control audit from October 2018 reflected that not all staff had completed infection control training and set an action for 90% of staff to have undertaken this training by the end of October. The training records showed that this had not been achieved. A medicine audit indicated that temperature recordings were not recorded regularly and that PRN protocols were required. We found however, that these actions had still not been fully completed.

Audits completed did not pick up on all the concerns we identified during the inspection, such as those regarding risks in the environment, staffing levels or the recording of consent. We also found that audits were not completed in all areas, as no care file audits had been completed, or staff recruitment audits, yet we identified areas for improvement in both of these areas.

A statement of purpose and service user guide were available to provide people with information regarding the service. We found however, that they did not provide people with accurate information and required updating. For example, they did not refer to the current management structure and did not accurately reflect the type of care provided in the home.

Although new systems were being implemented to help improve the safety of the service, we found that they were not always accurate. For instance, the DoLS tracker that had recently been developed did not include details of all of the people who had a DoLS application in progress.

Records showed that safeguarding incidents had been referred to the local authority safeguarding team appropriately. However, CQC had not been notified of these issues. This meant that we could not accurately monitor risks relating to the service. This was discussed with the manager who is now aware of what CQC needs to be notified of.

There was a range of policies and procedures in place to guide staff in their roles. However, we found that they were not always followed in practice. For instance, a diabetes policy stated that each person with diabetes would have an individual plan but we saw that these were not in place. This meant that the provider's policies and procedures were not always being followed.

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

There was no registered manager in post, however a new manager had been appointed and been working in the home for seven weeks at the time of the inspection. We asked people living in the home about their views of the management and they told us, "The new manager is very approachable", "I would recommend this place, it doesn't get any better than this" and "I have read newspaper stories and seen the television

about mistreatment in Care Homes, but it doesn't happen here."

Relatives agreed that the manager was approachable and making improvements within the service. Their comments included, "Already I can see positive changes taking place under the new management", "The management and staff here are very proactive and I have never come up against a stone wall" and "The culture here seems to be open and inclusive." Staff we spoke with were confident that under the new management overall performance would get better.

The manager was being supported in their role by the area manager who visited each month and by a registered manager from another of the provider's services. They also visited weekly and had been assisting with care planning improvements. The manager had a good understanding of their responsibilities and had a clear vision of how they wanted the service to improve.

We looked to see what systems were in place to gather feedback from people. Most relatives reported not having been asked to complete quality assurance surveys although the manager told us these had very recently been posted out to relatives. Records showed that meetings took place with people living in the home and their relatives. Areas such as meals and activities were discussed and we saw that action was taken based on the feedback received. For example, people said they could not always tell who was a staff member as they did not wear uniforms. The manager told us new uniforms had been ordered for all staff. Meetings were also held for staff and these provided an opportunity for staff to share their views.

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 12 HSCA RA Regulations 2014 Safe care and treatment The environment was not always maintained to ensure people remained safe. Medicines were not always managed safely. |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were not always effective. Care plans were not always accurate or reviewed regularly. |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff on duty to meet people's needs in a timely way. |