Mr Ajvinder Sandhu and Mrs Rajwinder Sandhu

Quenby Rest Home

Inspection report

Brightlingsea Road
Thorrington
Colchester
Essex
CO7 8JH

Tel: 01206250370
Website: www.quenbyresthome.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in April 2016 and rated the service as 'Good.' However, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the providers website did not display the correct rating for the location. We checked that the provider was displaying the correct rating in October 2016 and found that they were compliant with the regulations.

Quenby Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 26 older people who may have dementia.

Quenby Rest Home is situated in a residential area. The premises is on two floors with each person having their own individual bedroom and access to communal areas within the service. At the time of our inspection, 23 people were using the service.

There was a registered manager in post. The registered manager was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we identified breaches of 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.

Improvements were required regarding the storage, administration and auditing of medicines and to ensure that all risks to people's health, safety and welfare were effectively assessed. Care plans required further development to ensure records were complete, were legible and provided clear guidance of the support that people required. We have made a recommendation that the service consults guidance to further develop the Accessible Information Standard (AIS).

Staffing levels required review to ensure there were adequate numbers of staff on duty to support people and meet their needs and to ensure that care was provided at times to suit them. Staff had been recruited safely and were trained and supported to meet people's needs, however some refresher training was required.

Systems were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to. Processes were in place that encouraged feedback from people who used the service and relatives, however improvements

were required to evidence that action was taken in response. There was a complaints procedure in place and people knew how to make a complaint if they were unhappy with the service.

People's nutritional needs were being assessed and they were supported to eat and drink sufficiently. Where people required further input, referrals were made promptly to other agencies and people were encouraged to attend appointments with other health care professionals to maintain their health and well-being.

Care and support was based on the assessed needs of each person. However, improvements could be made to ensure the environment was suited to people living with sensory impairment or dementia. We made a recommendation regarding the further development of a dementia friendly environment.

Staff demonstrated a basic understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, however the completion of mental capacity assessments required improvement.

End of life planning required further improvement. We made a recommendation that the service consults a reputable source to further develop end of life planning.

Staff respected people's privacy and dignity and interacted with people in a caring, compassionate and professional manner. People were mostly encouraged to be as independent as possible but where additional support was needed this was provided.

Although some auditing and monitoring systems were in place to ensure that the quality of care was assessed, they had failed to identify the issues we found during our inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed to ensure that all risks to people's safety and welfare were identified and acted on and that moving and handling practices were safely managed.

Staffing levels required review to ensure that there were adequate staff who were deployed effectively to meet people's needs.

Medicines were not always stored and administered safely.

Staff were knowledgeable about how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had a basic understanding of the MCA, however capacity assessments were inconsistent.

The environment required further development to ensure that it was suited to people with dementia related needs.

People were supported to maintain good health and had access to ongoing health care support.

People's nutritional needs were assessed and they were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people.

People and their relatives were complimentary about the caring nature of the staff team.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records were inconsistent in recording care that had been delivered and in providing guidance to support staff in delivering care based on each person's individual needs and preferences.

End of life planning required further development to ensure that people's preferences were recorded.

An activities programme was in place.

People knew how to complain and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audit and monitoring systems were not effective in ensuring that the quality and safety of care was consistently assessed, monitored and improved.

Staff and relatives were complimentary about the approach of the registered manager.

The registered manager was committed and motivated to providing a good quality service.

Quenby Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 between the 24 September and the 1 October 2018 and was unannounced. The first day of inspection was undertaken by three inspectors and the second day was undertaken by two inspectors. As part of the inspection, we spoke with relatives, visitors and professionals.

Before our inspection a Provider Information Return (PIR) was submitted by the registered manager. 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 reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority, the safeguarding team and members of the public.

We spoke with two people who used the service and five people's relatives. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to eight people's care. We spoke with the registered manager and nine members of staff, including care and domestic staff.

We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service provided.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. On the first day of inspection, the senior staff member dispensed one medicine by directly touching the tablets and putting them into the pot. This is unsafe practice as there was a potential risk of the medicine becoming contaminated and medicines being absorbed through the skin of the staff member. Some people were being given medicines for pain relief. The MAR [Medicines Administration Record] chart stated the medicines were due at 1pm but these were being administered between 2 and 2.30pm. The staff member administering the medicine said that they would alter the time that people were given their next dose to ensure that there was enough time between doses and people did not receive too much medicine. However, they did not record the times that the medicine was administered to ensure this happened until they were prompted by the inspector.

Medicines were not always stored correctly. Room temperatures were recorded where medicines were stored. During the heatwave period, the temperature had been recorded as being above 27 degrees for four days. The registered manager told us that an air conditioning unit had been placed in the room to reduce the temperature however, there was no record that this had reduced the temperature to a safe level and temperatures continued to be recorded as high. Incorrect storage temperatures could reduce the effectiveness of medicines putting people at risk. No advice was sought from the pharmacy as to whether any further action should be taken or to ensure that the medicines were still safe to be administered. Eye drops which should be stored in the fridge were being stored at room temperature which could make these ineffective. The registered manager had completed an audit of medicines; however, this had not been identified and the senior staff member was not aware that the eye drops should be refrigerated.

It was not possible to check that people received all their medicines as required. We completed a random stock check of medicines and found that the stock of two medicines was not correct. The senior staff member told us that they checked the stock three times a week. However this was not recorded and the senior staff member was not able to explain the reasons for the discrepancy or to provide reassurance that people had received their medicines as required.

People's records contained assessments of risks to their safety and well-being. These covered the risk of falls, risks associated with mobility, from developing pressure ulcers and from not eating or drinking enough. However, information was not sufficiently detailed or accurate about how people's safety was promoted. One person's mobility care plan stated that they required a full body hoist for all transfers. The information was reviewed recently, and stated that no changes were needed. However, we observed two staff assisting that person to stand using a frame and without the use of the hoist. Additionally, staff held the back of the person's trousers, which presented a risk of causing discomfort and potential injury to the person and the care staff.

The registered manager told us that the person could be transferred without a hoist but if the person was tired or had an infection this may affect their mobility. There was no information in the care records to guide staff to assess the person's mobility and wellbeing to decide which equipment to use. Additional equipment such as a stand aid had not been considered. A stand aid can be used to support people who are able to

weight bear but may have some difficulties with mobility. There was no stand aid available which would have continued to encourage the person's mobility and independence instead of using a hoist.

Another person's falls risk assessment stated that they could rise from a chair of knee height but that sometimes the person did not want to stand and care staff assisted them. The assessment had been recently reviewed and no changes made. However, the person's mobility assessment, reviewed at the same time, said that the person needed full hoisting. The guidance was inconsistent and placed the person at potential risk of falls if staff did attempt to assist them to stand. One person's bed assessment stated that they required a crash mat on the floor next to the bed, however no crash mat was in place.

People did not have their own individually named slings. Communal use of slings meant that the wrong sized sling could be used. Some staff were unsure how to support people with their mobility, didn't know what size sling to use or stated a different size sling to that documented in the care plan. This placed people at risk as using the wrong size of sling can cause discomfort if the sling is too small and had the potential for people to fall out of the sling, if it is too large.

There was only one hoist available within the service and this placed people at risk of not being supported in a timely manner. The registered manager told us that if the hoist broke down, they would contact another service and arrange for a hoist to be delivered. They had not considered that there would be no way of assisting people to move, for example, to allow them to go to the toilet, while waiting for the hoist.

The fire risk assessment process had not identified potential concerns. People had Personal Emergency Evacuation Plans [PEEPS] in place, however some of these contained inaccurate information about people's abilities, the escape routes to use or the equipment required. The staff office contained the boiler for the service. The door to the room was missing the intumescent strip designed to seal the door in the event of a fire, although a channel in the frame indicated it had once been present. The registered manager had completed a fire risk assessment and an external company had completed an audit which included fire risks. The inaccurate information in the PEEPS and the missing intumescent strip had not been picked up through these audits and further advice had not been sought to determine if these concerns were a risk or not.

Risk management of the environment required improvement. Checks were completed and recorded on equipment including bedrails and pressure mattresses. However, in some bedrooms, the wardrobes were not secure and items were stored on top which could result in the wardrobe toppling over if someone tried to reach up. There were two windows upstairs which did not have restrictors. Window restrictors are required to reduce the risk of people falling out of windows.

Where people had been involved in accidents and incidents, these had been recorded. However, not all incidents been reviewed and explored to ensure that lessons were learned and the risk of re-occurrence was minimised. For example, where one person sustained a skin tear, the possible reasons for this had not been investigated or action taken to minimise the risk of it occurring again.

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

Following our inspection, the registered manager took action to ensure that staff knew which moving and handling equipment was required for each person and this was displayed in the office area for staff to refer to quickly. They also wrote to us to confirm that they had purchased a second hoist and to confirm that work had commenced to secure the wardrobes. They told us that restrictors would be fitted. A fire officer

also visited the service and identified deficiencies that the registered manager was working to address.

We received mixed feedback about staffing levels. One person said, "The staff are always so busy and staff do not have time to come and sit with me." One relative said, "The staff sit and talk to [relative] if they have time but the staff don't stay long and they keep leaving. Sometimes, I don't think [relative] has a shower each week and sometimes they are too busy to get to] them and they have an accident." Another relative said, "There is not enough staff for so many people with severe needs and [relative] can be anxious when left alone." A third relative said, "They [staff] haven't got time. One day when I visited in the afternoon, [relatives] bed was not made." One staff member said that staffing levels were not always maintained at the weekend when staff also needed to do the cleaning and the laundry alongside their care role. Another staff member said, "Some people require two carers to support them and this then only leaves one staff member to look after everyone else. [Registered manager] knows we need more staff and is aiming to increase the staffing to four staff on a shift, but sometimes when there are four staff on shift, staff don't do what they should be doing and disappear."

When people used call bells to request assistance, staff responded to these promptly. However, on one occasion a person requiring two members of staff to support them to use the toilet had to wait until the one staff member present found another staff member to help them. During that time the person said, "They [staff] will be too late. I'm going to have an accident." The staff member who had been present, had no means of summoning assistance from another staff member promptly. On another occasion, there were no staff present to intervene when one person became anxious with another. Another person living in the home urged them to, "Calm down." Staff arrived at that point and offered both reassurance and distraction to prevent any increase in anxiety or distress. The registered manager explained how the numbers of staff were determined by the dependency levels of the people at the service. They had recently reviewed the staffing levels and increased the number of care staff to four on each shift. However staffing levels required further review to ensure that staff were effectively deployed, considering the layout of the building and the numbers were sufficient to meet people's individual needs.

The service had a food safety inspection by the local council in April 2018 and received five stars. There were three areas for action which had been addressed. Cleaning schedules were in place to ensure standards were maintained and this contributed to reducing risks associated with food preparation and storage. However, three cartons of fruit juice opened in the main dining room were being stored at room temperature, despite the label stating that they should be stored in a fridge.

Staff confirmed they had access to sufficient supplies of Personal Protection Equipment [PPE], such as gloves and aprons and had up-to-date infection control training. However, slings used to mobilise people were shared, including toileting slings. We were told these were washed regularly, however toileting slings should not be shared as there is a potential risk for cross infection. After the inspection, the registered manager told us that more slings had been purchased.

Staff had received training in recognising and responding to abuse and could provide examples of what might lead them to be suspicious and concerned. Staff understood their obligations to report any concerns both within the organisation and to relevant external agencies. Information about contacting the local safeguarding team was available at the front of the home and there was a whistleblowing policy in place which staff told us that they would use it if they had any concerns about the support being provided.

Safe recruitment practices were in place to ensure staff were of good character and suitable to work with those using the service. Relevant checks had been completed prior to new staff starting work at the service. These included undertaking a criminal record check with the Disclosure and Barring Service (DBS), obtaining

references, and proof of identity.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions.

The service was mostly working in accordance with the MCA and associated principles. Where people lacked capacity, some mental capacity assessments were in place and best interest's decisions were recorded. However, this was inconsistent. For example, one person's assessment did not show who was involved in the assessment, or how staff had tried to communicate the information to help them to understand. It stated that the person was unable to take medicines on their own so that staff should administer these. The assessment focused on the safe administration of medicines rather than on the person's ability to give informed consent about taking them. The person gave implied consent by continuing to take their medicines, but there was no indication of their capacity to understand what they were for and what would be in their best interests, if they refused.

Staff had received training in the MCA. One staff member said, "It was one of the first training sessions I did. It is about knowing whether someone has the mental capacity to make a decision for themselves. We must involve them as much as possible in any decision making." We saw that staff sought people's consent and acted in accordance with their wishes.

People's care records contained information about their hydration needs and the support that was required to monitor their wellbeing. Some people had a target fluid intake to try and achieve. Fluid records were not always complete or clear and did not evidence that people consistently drank enough or reached their target. Fluid charts contained a column for recording urinary output and these were completed in all cases, despite it being impossible to measure some people's output because they wore pads. This evidenced a lack of staff understanding about how to use the charts and meant that the fluid intake recorded may not be accurate.

People had access to fluids and staff offered support and encouragement to people to ensure they were hydrated. Water jugs were taken to people's rooms daily and there was a water cooler in the dining area for people to help themselves. However, we found gaps in the recording of people's fluid intake. One person's records did not record any fluids between 5pm on 8 September 2018 and 9am the following day. For

another person, who was prone to urinary tract infections and had a catheter, their target intake for fluid was recorded at 1500ml. On one day, their records showed an intake of 1230ml and on another day, an intake of 1150mls was recorded between 8am and 1pm. There were no further entries to confirm fluid intake after 1pm on that day and no entries until 8am on the following day. On the day of inspection, one person had no fluid recorded from waking until 3.15pm.

We discussed the lack of effective fluid recording and monitoring with the registered manager who acknowledged that records were incomplete. After the inspection, they wrote to us to advise that a new system had been implemented and checked by the senior to ensure records were complete and all fluids were recorded

People's care records identified where they were at risk of malnutrition. Weekly weight loss was monitored and analysed and where required, action had been taken to prevent any further loss. For example, to encourage the person to finish their meal or to see the dietician. There was guidance for staff in place for three people who were at risk of weight loss. An action plan to address this risk included offering additional snacks and that their food should be fortified to increase their calorie intake by adding butter, cream, and cheese. However, the chef said they did not fortify meals which demonstrated a lack of awareness of the action plan. Despite this, the chef showed us how "build up" was used as a supplement in drinks to promote weight gain.

The service worked alongside other organisations and was involved in the 'Prosper Project' which is a collaboration with Essex County Council, which aims to improve safety and reduce harm for vulnerable people in care homes. The project aims to reduce falls, pressure ulcers and catheter infections across care homes and there was information displayed to show how this was working. People's care records demonstrated that where required, referrals had been made to other health professionals, for example, GP's, chiropodists and Speech and Language Therapists [SALT]. One relative said, "Quenby have addressed [relatives] health issues and they called the GP straight away so that [relatives] diabetes is being dealt with more thoroughly."

There were records for the handover of information between shifts. These showed information of importance about people's wellbeing, any visitors or events taking place that incoming colleagues should be aware of or monitor for individuals. A verbal handover was also held so staff could pass over key information. This contributed to maintaining continuity of care when there were changes to staff on duty.

Bedrooms were mostly clean and fresh and were personalised with people's possessions. There was level access through the ground floor of the home, including access to the garden and a lift available for people to get to the first floor if necessary. However, improvements could be made to ensure it was suited to people living with sensory impairment or dementia. Some areas of the garden were difficult to access, and walls and handrails in corridors were of similar colour so that people with a visual impairment may not be able to easily identify the handrails to use as support. There were limited sensory or comfort items around the service such as memory books, old newspapers, scarves or handbags that people could pick up and use to stimulate thoughts and memories, which are important when caring for people with dementia. While there were recent photographs on people's bedroom doors to help people recognise their bedrooms, consideration had not been given to using memory boxes. Memory boxes contain items or pictures that are of relevance to individuals and could further assist in helping them to orientate themselves.

We recommend that the service explores further current guidance from a reputable source on improving the design and decoration of accommodation for people living with dementia.

Staff showed people the food on offer so that they could make a choice on the day. Although there were photographs of the options available on a magnetic board on the main dining room board, this showed that roast gammon was an option. However, this was not accurate as staff offered people chicken or fish.

People were complimentary about the food. During lunch, staff who assisted people, sat alongside those who required support. This included one person who ate their meal in their room. We heard staff explaining to them what they had, checking if they liked it, and engaging in conversation. This contributed to making the mealtime a social experience.

Staff felt supported and received some training to provide them with the necessary skills to carry out their roles effectively, however some refresher training was required. One staff member said, "I have done lots of training since I have been at Quenby." However, one staff member said, "We are behind with training at Quenby. I have not done moving and handling training, but I did this in my previous role." A second staff member said, "I did moving and handling last week but I missed first aid." We saw that training was planned in many areas including moving and handling and first aid. Additional training was also planned in areas such as promoting continence and dignity and support. New staff shadowed existing staff members to learn the role and completed an induction although this was not formally recorded. One staff member said, "I had an induction and it included how the call bell system worked and the fire arrangements." Supervision was held to give staff the opportunity to talk through any issues, seek advice and receive feedback about their work practice.

Good

Is the service caring?

Our findings

People and relatives told us that they were well cared for and were complimentary about the care provided. One person said, "The staff are nice and we get on okay." Another person said, "I get on alright with people and on the whole they are quite good." One relative commented, "Some staff are brilliant and they are good people." Another relative said," I am really pleased. The care at Quenby has been really good. They [staff] are friendly and always open the door with a smile. They [staff] are very patient and there is nothing that I am not happy with." A third relative told us, "They [staff] have done a marvellous job with [relative]. [Relative] has gone to the right place and I can't knock any of it. They have made a new man of [relative] and I can't thank them enough."

One relative said that there were occasions when their relative's fingernails had not been cut and so the family had done this for the person. They said, "A lot of staff have left and there has been a new intake of staff so maybe they haven't got as much experience." The registered manager told us this would be addressed.

Staff spoke with people in a respectful and polite manner. Where one person became distressed and was calling out, a staff member got down beside their chair, made eye contact, and held their hand until they became calmer. Where one person could become upset their care plan stated that staff should not engage in any argument with the person, which could cause them to become more upset. However, their care record also said that, "Carers should not permit any rude comments and should explain to [person] that this behaviour is not acceptable." This response might need further consideration to ensure that it did not escalate the situation.

Despite this, we saw that staff managed situations well and were patient in their approach. Where one person was groaning slightly, a staff member checked that they were all right and tried to establish why this was. The person did not clearly state their wishes but the staff member managed to establish from their responses that the person would like a cold drink. The staff member offered them two jugs of drink of different colours, so that they could make their own choice by pointing at one of them. Where staff accompanied a person along the corridor who was using their frame, we saw that staff did this as the person's own pace without rushing them. Another staff member stopped what they were doing straight away and assisted someone who was anxious and asking where they should go.

People's care records contained information showing when they or their family members were involved in discussing and reviewing their care. The care records also reflected what people could do for themselves and how staff should encourage this to promote and maintain people's independence.

People were involved in how the service was run and relatives and resident's meetings were held, however, it was not always clear that action had been taken to address areas that had been suggested for improvement. One staff member said, "[Registered manager] is very hot on involving people in making choices." The registered manager acknowledged that outcomes needed to be recorded to evidence where improvements had been made.

Staff knew people well and had developed good relationships. Although the staff member responsible for providing activities had been in post for only eight months, they were able to give us comprehensive information about people's likes and dislikes and to show they understood people's backgrounds and preferences. People had keyworkers and there was a poster in each person's room which included a photograph of their keyworker, what they could help with and a little bit about themselves including what they liked which could encourage a rapport and generate conversation.

Staff respected people's privacy. We saw staff knocking on people's room doors before they entered their rooms. This included a member of housekeeping staff who asked if they could go into one person's room and wash the floor.

We saw compliments about the service which said, "Everyone was very happy and friendly and we got a good feeling being there. Keep up the good work." And, "The staff at the home were clearly dedicated in looking after people in their care, even in the most difficult of circumstances." A third compliment said, "Clean and pleasant with happy residents and it's a pleasure spending time in the home."

Requires Improvement

Is the service responsive?

Our findings

The recording in people's care plans of the care delivered was inconsistent. We also found inconsistencies in the guidance provided for staff on how to deliver care to meet people's individual needs and preferences. For example, one person's care plan showed that they liked either a bath or shower but did not specify how often this was needed to maintain their hygiene and comfort. There were gaps in the person's bath and shower record and on two occasions, there was no bath or shower recorded for three weeks. Another person's care plan stated that they needed staff to support them with a shower or a full body wash each day to meet their personal care needs. Despite this, their record showed that these had only happened once a week. For both people, their daily logs lacked sufficient detail to show what specific personal care staff had delivered daily. In some cases, records on the daily logs were illegible and so could not show the care people received to evidence that care focused on their individual needs. The registered manager had identified that some records were illegible and there was guidance displayed in the office about the importance of completing documents correctly, however, this had not been effective in ensuring that improvements had been made.

Some practices were not always person centred to ensure that they met people's individual needs and preferences. Four people had been supported to have personal care, were dressed, supported back to bed and had breakfast by 7am and a staff member confirmed that this was usual practice. One of these people was very sleepy while a staff member tried to support them to eat and the staff member did not appear to consider supporting the person later when they were awake. During handover, one staff member commented that "none of their people" had their breakfast before they started their shift at 7.30am. We were concerned that people were being supported to suit the staffing arrangements rather than at a time that suited them and their preferences. The registered manager said that they did spot checks to observe practice but acknowledged that they hadn't complete a spot check in the early hours of the morning recently and would do so to ensure that care was person centred and address any concerns.

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

The registered manager was aware of the Accessible Information Standard (AIS) and some information was provided in larger formats. There were staff photographs with their names on display in the hallway so people and their relatives could see who supported them. The menu was available in small print on menu stands that could be displayed on dining tables, however none of these were on the tables. The menu that was displayed above the kitchen hatch was also in small print and not clearly visible to people living in the home. The dementia calendar in the end living room showed an incorrect date which could have caused confusion. People's care plans did not always clearly indicate if they had specific communication needs or how this could be met in a way which best suited them.

We recommend that the service further develops the implementation of the Accessible Information Standard.

People's care records did not always detail their preferences and choices for their end of life care. In one care plan, there was information about not resuscitating the person should they have a heart attack. However, in other care plans, information about people's preferences and wishes were not documented in line with best practice for people coming to the end of their lives. There was no-one nearing the end of their life at the service currently. Training was planned for the staff team on end of life care.

We recommend that the service consults a reputable source to further develop end of life planning.

There were opportunities for people to take part in organised activities. There was an activities co-ordinator in post who considered people's preferences when they planned activities. They were knowledgeable about people's interests, likes and dislikes. The activity co-ordinator was flexible and did not always follow the plan if people wanted to do something different from that intended. People had taken part in karaoke, light exercise and arts and crafts and had accessed the internet so that one person could watch old films and comedies. There were opportunities to engage in quizzes, which one person particularly enjoyed, and floor darts was popular with others. One staff member said, "There is an activity co-ordinator and they are very good with the residents and have the right attitude although they don't always interact with everyone when doing the quizzes and need to move around so everyone can hear."

The activities plan was displayed so that people knew what was on offer and those who requested it were given their own copy. Some of the activities on offer and planned included a mocktail party, circus day and a curry night. Where activities had taken place, the impact on those who participated was recorded to determine if it had been enjoyed and was beneficial to people and this information as used to plan future activities.

Where some people choose to remain in their rooms, engagement was
recorded including ways to try and encourage more interaction. One person had a list of subjects that interested them for staff to talk about and guidance that said, 'Engage in conversation in small steps to gain [person's] confidence.

There were opportunities for people to go on outings and people had been on a trip to the seaside in July. Another outing was being arranged to go birdwatching as one person had suggested they would like to do this. Funds had been raised for trips through a recent fete and a "knit and natter" session involving people from the local community.

Requires Improvement

Is the service well-led?

Our findings

Auditing systems and quality assurance processes had not identified all the concerns and areas for improvement that we found during this inspection. For example, medicines management, risk assessment, moving and handling practices, records management and care practice. Where concerns had been identified through auditing by the registered manager, it was not always clear that action had been taken to ensure this improved. While the provider visited the service, there was no action plan available at the service that the registered manager could work towards to address any areas of concern or development.

Incidents and accidents had not been fully reviewed to ensure that lessons were learned and the service continuously improved.

Whilst we acknowledge the registered manager responded and acted during and after our inspection to rectify some of the shortfalls found, the current arrangements for monitoring the quality of the service need to be reviewed and embedded. This is to ensure all areas for improvement are identified, and a clear action plan is put in place to address concerns and evidence continuous improvement.

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

The registered manager had identified that they were struggling to keep on top of the workload and because of this some auditing and spot checks had not taken place. They had requested additional support from the provider and a deputy manager was due to start at the service to provide further management support. The registered manager felt that this would allow them to address the areas for improvement, develop the service and have more effective oversight.

The registered manager had been in post since October 2017. They were passionate about providing a good quality service and acknowledged where improvements were required. The local commissioner's quality improvement team had been providing support to the service and we received feedback that the registered manager had worked well with local safeguarding teams and with the local fire officer who visited the service.

We received mostly positive feedback from staff and relatives about the registered manager. One staff member said, "I can raise concerns with [registered manager] and they will put it right." Another staff member commented, "[Registered manager] works really, really hard and has been very supportive. They are the best manager I have had." One relative said, "[Registered manager] is approachable. Sometimes the door to the office is closed but they are always around the home and will always stop and chat." Another relative said, "There is a really lovely manager and the senior is approachable too."

The registered manager understood their role and responsibilities and explained how they kept up to date with changes in the care industry which included accessing the CQC website, attending meetings, training and networking with other services.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans contained conflicting information and did not provide sufficient guidance to staff. Care practice did not always meet people's individual needs and preferences. 9 (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored and administered safely. Environmental and individual risks had not been effectively assessed or action taken to mitigate the risks. Moving and handling practices were not safe. 12 (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Monitoring and audit systems were not effective in highlighting or addressing issues within the service.