Heathbrock Limited

Chester Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 26 and 28 June 2018 and the first day was unannounced.

At the last inspection we found multiple repeated breaches of legal requirements in regards to safe care and treatment, nutrition and hydration, dignity in care, record keeping and overall governance.

Following the last inspection, we asked the registered provider to confirm what they would do and by when to improve its rating from Inadequate to Good.

On this inspection we found that a number of improvements had been made but further work was required to ensure full and sustained compliance with the regulations.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Chester Lodge is '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 accommodates 40 people in one purpose built building which is spread over 3 floors. At the time of the inspection 24 people were living at the service.

The registered manager had been absent from the service since April 2018 and we were informed that they were unlikely to return . A registered 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. In the interim period, the Clinical Lead Nurse had taken on the manager role.

The quality assurance systems in place had been reviewed and the registered provider now acknowledged that it previous monitoring of the quality and safety of care had been ineffective. They had made use of external consultants as well as commissioners to assist them in identifying shortfalls and making improvements. People and staff confirmed that the registered provider had been open and honest with them about the issues regarding the service and what they intended to do to put things right.

People received their medication as prescribed. However, topical medication was not always stored in a safe and secure way. An accurate record was not kept of its application nor that of prescribed thickener. Risk assessments were not always in place where medication posed a specific risk to a person's health and wellbeing such as from fire or excessive bleeding.

New staff employed at the service had an induction and worked with more experienced staff to ensure they were confident and had the required skills. Recruitment checks had been undertaken prior to employment but references were not always taken from the last employer. This meant that there was no assurance in place of a person's suitability for the post. We made a recommendation in regards to this.

Accident and incidents were effectively monitored. Review of these included identifying causation, on-going risk and trends. Steps were taken to reduce the reoccurrence of accidents and there was evidence of their effectiveness. Risk management plans did not fully outline for staff what was required to keep a person safe.

Care plans were being reviewed in order to record people's needs accurately but some improvements were still required to ensure they were complete and accurate. Records were better personalised to reflect people's individual preferences about how they would like their care and support to be provided.

Staff practice showed that people's consent was considered before care or support was provided. Staff showed a better understanding of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but supporting documentation still required improvement. We made a recommendation that this was reviewed to reflect how specific decisions for people who may lack capacity had been reached and made in their best interest.

A number of people were at risk of malnutrition or dehydration. Staff monitored this and food and fluid charts were completed in detail to reflect what people had eaten and drunk over a 24 period. This helped to inform a further assessment of the person's nutritional status. Referrals to health professionals were made when concerns regarding people's health were identified and advice provided by health professionals was implemented to ensure that risks to people's health and wellbeing were minimised.

People said that they felt safe at the home and were very pleased with the care that they received. People and their relatives felt that staff did their outmost to support people and protect them from harm. Staff were aware of their responsibility under Safeguarding to keep people safe and were confident in how and when to highlight concerns .

The premises were cleaner but some aspects still required refurbishment and repair. We were informed that there was a plan in place to do this once finances were available to support this. Some checks on the safety of the service had not been carried out with the required frequency but steps were taken to correct this. We made a recommendation in regards to ensuring that checks were carried out in a timely manner.

Staff respected people's opinions and choices in how they wanted their support to be provided. People were kept comfortable and treated with dignity and respect. People informed us that the staff were caring and always did their best to look after them.

Staff attended annual training sessions in areas such as moving and handling, first aid and safeguarding adults to update their knowledge and skills. Improvements were planned to the quality and frequency of staff supervisions.

Meetings were held with people who used the service, relatives and staff to discuss the future direction of

the service and to seek their opinion. Staff were positive about the staff team and reflected on the changes made to the service, this included improved communication and documentation. Staff were found to be more organised and had a clearer understanding of their role and responsibilities.

People and or their relatives received opportunities to be involved in review meetings to discuss the care and treatment provided. People received opportunities to participate in a variety of activities and staff had time to spend with people. The registered provider's compliant procedure had been made available and used satisfactorily.

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 completely safe.

Although improvements were evident, further action was required to ensure that the management and administration of medicines was safe.

Recruitment processes were not fully robust as information has not been received from previous employers.

Checks were not always made in a timely way to ensure the safety of the premises.

Risk assessments were not always in place to assist staff in provider safer care and support. Accident and Incidents were recorded and reviewed.

Is the service effective?

Requires Improvement

The service was not fully effective.

Mental capacity assessments were completed but improvements were required to ensure assessments and decisions were consistently completed.

Improvements had been made to meeting people's food and hydration needs, including the documentation to record this information.

People's health care needs were managed sufficiently and monitored, and staff were working with external health care professionals.

Staff received an induction; on-going training and improvements were being made to the frequency of staff supervisions and appraisals.

Is the service caring?

Good

The service was caring.

People were cared for by staff that showed kindness and

compassion in the way they supported them. Staff were knowledgeable about people's individual needs.

People had information about independent advocacy services to represent their views if needed.

Improvements had been made to how staff respected people's privacy and dignity and independence was promoted.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People's needs were being reassessed and planned for. Care plans varied in detail as work was progress to re-write them.

Improvements had been made in how people received their care and treatment. End of life care plans had not always been completed.

People received opportunities to participate in activities.

People had information made available about how to make a complaint and the process had been followed.

Is the service well-led?

Requires Improvement

The service was not completely well led.

Improvements had been made in the governance of the service. There was new leadership and improved oversight and accountability. The service required additional time for improvements to be embedded and sustained.

Staff were positive about the management team and their approach in making improvements to the service.

People received opportunities to give feedback about the service and were kept up to date with the changes.

Chester Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 28 June 2018 and the first day was unannounced.

The inspection was carried out by two adult social care inspectors.

Prior to the inspection we reviewed the information that we had received from the registered provider such as actions plans, and statutory notifications.

We also spoke to the Local Authority and Clinical Commissioning Group who had been supporting the service since the last inspection. They provided positive feedback on the changes that had taken place over the last few months.

During the inspection we spoke with ten people who used the service, three relatives, and nine members of staff. We also spent time with on Director of the service and the business support manager. We spent time, on both days, observing care delivery and people's dining experience.

We reviewed records relevant to a persons care : this included eight Medicines Administration Records, nine care plans and supplementary charts. We also looked at records kept in regard to the management of the service including two recruitment files, training records, maintenance records and audits.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in September 2017, there was a failure to ensure that care and treatment was provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection, we found that whilst a number of improvements were evident, there was an on-going breach of the regulation.

Prescribed creams were kept in people's bedrooms so that they could be used at the point of personal care being delivered. However, as in September 2017 there was no individual risk assessment or topical medicines record in place to ensure that this was managed safely. There was no information about the frequency of use, thickness of application and areas of the body to which the cream is applied. This information should be readily available to the person applying the medicine. We saw that creams were inappropriately stored on window ledges in direct sunlight, on the back of toilet cisterns or on table tops. Some were subject to environmental contamination and should be discarded after a period of use but there was no always an 'opened' date on the product. Records should be kept of any creams applied by staff, both nurses, if applicable and care staff. However, nurses had been signing for the applications of creams when in fact the care staff had applied them. This is known as secondary dispensing and is not safe practice.

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

On previous inspections, we had concerns about the use of thickening powder prescribed to thicken fluids to the correct consistency to reduce the risk of choking where the person had swallowing difficulties. Staff now recognised that this was a prescribed medication and had to be used and stored safely and correctly. Containers had dispensing labels that gave the name of the person it was prescribed for and directions as to the amount that should be used. The amount of thickener required by each person varies dependent on the consistency required. Staff were able to tell us how much product was required in fluid to achieve the right level of consistency for the individual and this was also recorded their care records. However, a complete record was not kept of when fluids had been thickened and to what consistency. On the second day of the inspection, we found that steps had been put into place to remedy this.

Medicines were stored safely in the medicines room and there was no excess supply. Those stored in the fridge were kept at the correct temperature and the maximum/ minimum temperature taken on a daily basis.

We looked at a sample of Medicines Administration Records as well as the stock of medicines available and found them to correlate. Where medicine was delivered via a 'patch' staff recorded its application including the specific location on a body map. The site of application of a patch was rotated with each application in accordance with the manufacturer's instructions. If medicines were taken 'as required' (PRN), there was additional information available as to why, how and when it was to be offered. This meant that people received their medicines as required.

Improvements were still required to demonstrate how risks to a person's health and wellbeing were being identified and addressed.

Staff were not all aware of the fire hazards associated with paraffin based emollient creams and a risk assessment had not been considered especially where the person smoked. This meant that there was an increased risk of harm to the person as risks were not identified and minimised

Some people were prescribed medicines to treat and prevent blood clots. There was insufficient information available for staff to ensure that these medicines were used safely and effectively. For example: the reasons for use, the possible side effects and what to do if these occur, the effects of other medications, foods and alcohol on oral anticoagulation treatment, and when and how to seek medical help

People's call bells were available and accessible for people to use. Some people had been identified as being unable to use a call-bell and risk assessments outlined the reasons why. Staff informed us, and we observed that frequent checks were made on those people unable to summons help in this way. However, risk management plans did not make it clear for staff the level of monitoring that was required and there were no written records of what checks were made and when.

One person was on a fluid restriction of 1500 mls per day and the rationale for this was clearly documents in their care plans. It also stated that should the person continue to drink over this amount the GP should be alerted. Fluid Charts indicated that this did occur on a number of occasions: 9 May 2018 1760 ml, 11 May 2018 1700 ml, 23 May 2018 1800 ml, 5 June 2018 2,070 ml, 11 June 2018 1950 ml, and 17 June 2018 1980 ml. However, there was no discussion with the GP. Staff told us that they believed that the person understood the risk associated with drinking more than the recommended amounts and so could not restrict this. However, there was no risk assessment outlining the risks to the person's health of drinking above the recommended level and their ability to understand and accept this risk.

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

In addition, improved procedures were in place to share information with staff about people's risks and the action required to manage these effectively. For example, the handover record used to share information with staff at daily handover meetings was more detailed. This information included known risks people had and any new concerns and the action required to respond to these. Staff were better organised with senior staff delegated tasks and responsibilities.

There were systems in place to assure, as far as possible, that only people of suitable character and skill were employed at the service. Following completion of an application form, details were verified identity checks undertaken and interview recorded. A check was also carried out with the Disclosure and Baring Service (DBS) to ensure that the person did not have criminal convictions or cautions to be considered. However, we found that although two references were in place for two new starters these were not from the last employer.

We recommend that the registered provider ensure that recruitment processes are reviewed to ensure that there is sufficient evidence of conduct in previous employment concerned with the provision of services relating to health or social care.

The registered provider used a dependency tool to assess the hours of support required; this now took into account factors such as the layout of the building or the location of those people requiring the most care.

Call bells were answered in a timely manner and we did not observe anyone having to wait for personal care.

A record was kept of accidents and incidents and these were reviewed for themes and trends. Factors such as the time and location of the fall were now taken into account when looking at the overall trends within the service. There was a review of what had led to the accident and what could be done to prevent this from reoccurring.

Health and safety checks were carried out on the premises, equipment and the utilities such as gas, electricity, water, hoists and lifts. However, not all checks had been done in the timescale required. For example water temperatures, water flushing in empty rooms, and emergency lighting had not been checked since March 2018. The registered provider informed us that as there was no handyman the checks had been missed. By the time we had visited on the second day, these checks had been carried out and a schedule of checks put in place to ensure that these were done as required. There was a fire risk assessment in place and each person had a personal emergency evacuation plan in case of an emergency.

We made a recommendation that the register provider review their safety and maintenance programmes to ensure checks are carried out in line with health and safety guidance.

Improvements were evident to the standards of cleanliness within the building and people's rooms. Some areas were still in need of repair which made it difficult to ensure that they were clean. The registered provider had a refurbishment plan which, they informed us, would be implemented once the service was compliant with CQC and admissions had recommenced.

Staff had an understanding of safeguarding and how this applied to their day to day work. Staff were confident that if they reported concerns that they would be addressed. The registered provider ensure that they reported to the local authority low level concerns on a monthly basis: these are occurrences where there was a potential for harm or a low impact on a person.

Requires Improvement

Is the service effective?

Our findings

We previously identified a failure to ensure that care and treatment was provided in line with the Mental Capacity Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection, we found that improvements were evident in both recording and knowledge.

The 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 procedure for this in care homes is 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.

Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, the impact of refusing treatment or how to keep themselves safe. The clinical lead nurse informed us that they were in the process of reviewing the information held on people whom could not make such decisions due to their cognitive impairment. They showed us a 'decision specific' mental capacity assessment recently completed with regards to the use of bed rails as it had been deemed a restrictive practice. A MCA assessment demonstrated that the person lacked mental capacity to agree this restriction or to their care being provided in this way. Other least restrictive options had been considered but following a 'best interest' discussion it was concluded that this was the safest option. The staff member was able to talk to us about other situations and persons to which they were going to apply the same principles.

The DOLS application and other care records for one person indicated that they received their medication covertly (hidden/ disguised in order to be given without valid consent). There was no MCA assessment or Best Interest decision in regard to this. Staff told us that this was not given covertly and that the method of administration (dissolved in juice) was due to the person's physical health and preference not in order to disguise. Records indicated that when the person refused, it was not administered. Staff indicated that the person had fluctuating capacity.

We recommend that the registered provider maintain comprehensive and accurate records about people's mental capacity and any decisions which need to be made by others on their behalf.

Staff had an understanding of the MCA and were able to talk to us about making decisions in a person best interest. Staff were due to attend further training on the 16 July 2018 in regard to this.

Relatives or others were now asked to participate in a discussion or sign to say they had been consulted in regard to decisions rather than, as previously, being asked to consent without the legal authority to do so. Where a third party had legal authority to act, the person's care plan contained a copy of the document and indicated whether this was for financial and/or health decisions.

At the inspection in September 2017, we found a failure to ensure that the nutritional and hydration needs of people were met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection, we found that improvements had been made and there was no longer a breach of regulation.

A record of those people with special dietary requirements was kept in the kitchen. This was consistent with information contained within people's care records. For example, a person whose preferences were vegetarian was provided with a vegetable quiche with salad for lunch. Those who required thickened or fortified products were provided with these.

We observed people in the dining room being supported appropriately with their lunch if required. Staff were attentive. One person initially did not want support, but then changed their mind when staff asked again. Staff ensured that where required food was cut into manageable pieces, or softer options provided. One person had a visual impairment. We observed staff giving clear instruction "Your spoon is to your left" and "I have put a drink down just to your right".

Some people were at risk of malnutrition or dehydration by virtue of their health conditions. Where a person needed to be monitored for food and fluid intake there was guidance for staff as to the optimum amount for that person. Staff kept an accurate record of what had been offered, refused and consumed and nurses had an oversight of their daily chart. This meant that an assessment of a person's intake could be assured and accurate clinical assessments made.

Feedback from external health care professionals overall gave a positive picture of how people's needs and risks were better managed. No concern was raised as to how nursing needs were met. They spoke positively about the increased input from the clinical lead nurse and the service provider.

New staff had an induction to the service and an opportunity to work alongside more experienced members of staff. We observed this taking place on the first day of the inspection. New staff informed us that they felt supported and that the introduction to the service was sufficient. The Care Certificate is a set of standards that all care staff should adhere to and this training was available to new members of staff as part of the induction process.

A check list had also been devised for Agency staff to help ensure that they were aware of key aspects of the service. They were also asked to complete a feedback sheet as to whether anything could have made the shift easier for them: no concerns had been raised in this process.

Staff told us that they continued to be given the opportunity to undertake training that was essential to their roles such as moving and handling, health and safety and safeguarding. Staff also confirmed that they had the opportunity to meet to discuss concerns at handover. The registered provider informed us that improvements were required to the frequency of staff supervision and appraisal. Nurses did not currently have clinical supervision but this was to be addressed by looking to employ a new manager who was a qualified nurse.

Good

Is the service caring?

Our findings

At the inspection in September 2017, we found that people were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We observed more positive interactions on this occasion and there was no longer of breach of the regulations.

People were positive about the care they received and the staff. Comments included "I am very happy", "I love it here", "hey take care of you here", "They are nice staff, they really are". A number of people told us that they had been very upset about the last inspection report and that it did not mirror their thoughts on the service. Relatives told us that they felt welcome at the home, that they could visit at any time and had no current concerns.

As previously, most people had their bedroom doors open all day but this choice was now recorded in their care plans. At the last inspection, the registered manager told us that this was because people liked to see what was going on. However, at the time many people were positioned such that they could not see out onto the hallway. We found that people had now had their rooms rearranged to make this possible.

The majority of people were up and in the lounge area for the day which they confirmed was through choice. Beds were made in a timely manner so that people could return if they so wished. We saw that one person was in bed with no lower garments or over sheet and their catheter bag clearly visible. We checked their care plan which indicated that this was how they liked to be. We spoke to the clinical lead nurse about looking at ways of discreetly covering catheter bags to maintain privacy.

Staff knocked on bedroom doors prior to entering a room and they described how they maintained dignity as far as possible when they carried out personal care and support. One person told us that staff always afforded them dignity as they required support in maintaining their continence and staff made this less embarrassing for them.

Staff interacted with people in a friendly and caring way and it was obvious that they had a good relationship with some people and their relatives.

We observed two people being transferred using a hoist. During this process staff gave clear instruction, were unhurried and adopted a humorous approach: one of them laughed "Look at me [name], look at me and my ugly mug"- to keep them distracted. Staff supported another person to stand using their zimmer frame; they urged the person to take their time, gave clear instruction and spoke softly and reassuringly to them. Another member of staff started singing to a person who started laughing and smiling. This person also started worrying about a relative's health. Staff were quick to offer reassurance which helped to calm them.

People's care records contained information as to whether the person preferred to have a same gender staff member for personal care. People's diverse needs had been assessed and staff had important information

about people's individual needs, such as their religion and spiritual needs.

Care plan records were stored securely in a locked office. Care records contained the relevant paperwork for those people who did not want to be resuscitated in the event of their death. This information was placed prominently at the front of the care record so that staff could easily access this information if they needed. Check charts and a one page profile were kept in the person's room but this was kept discreetly in a folder on the back of the door.

Requires Improvement

Is the service responsive?

Our findings

On previous inspections, there was a failure to ensure that accurate and comprehensive records were held in respect of each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We found that some improvements had been made but work had not yet been completed and the regulation was not met.

The registered provider intended to use a bespoke electronic system for care planning but an interim solution had been introduced. The clinical lead nurse was working with representatives of the Clinical Commissioning Group to ensure that care plans were accurate, person centred and reflective of a person's holistic needs.

We looked at some of the new care plans introduced in May and June 2018 and found them to be much improved. However, we found that some information was still missing or contradictory within the new care plans. For example:

One person had a skin integrity care plan which showed a moisture lesion to the base of the spine and a wound chart was in place and updated. However, there was no information as to how often dressings should be checked/ changed. Another person's care plan contained a good level of information about their needs including that they had expressed a preference for staying in bed. The care record outlined the risk to their pressure areas, and regular turns were in place. However, the person showed us some deterioration to skin on the right lower leg which was not recorded in the skin integrity care plan. These were referenced in daily notes as "scabs to right lower leg"; the GP had assessed and prescribed oral and topical medicines.

Another person had been seen by the continence nurse and it was advised that they were encouraged to use decaffeinated products and had a reduction in fluids at night time. This was being done but the information had not been recorded in their care plan.

Records indicated that a person had' seizures' but there was no further information as to the type and nature of the seizure or how staff were to respond. We spoke to the nurse who assured us that they would discuss this further with the persons GP to gain a better understanding of their diagnosis.

People's communication and sensory needs had been assessed but the information as to how to meet these needs was limited. Information had not been made available in different formats to ensure that no person was disadvantaged due to their sensory or communication needs. This meant the provider had not considered the requirements of the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss.

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

People's care records now contained a short profile, which included important details about the person's

life such as life history, and care and treatment needs. This information was used as an easy read reference by staff to know people's needs and was particularly useful to inform new or agency staff about people. In addition, staff were required to read people's full care plans. Staff told us and records confirmed, any changes to people's needs were discussed at staff handover meetings and care plans were reviewed and updated monthly or earlier if required.

Care plans had been reviewed to ensure that they contained enough information to assist staff in delivering care in line with a person's choices. Care plans gave information regarding preferences for gender of carer, when to receive care how to provide it. For example" [name] likes crisps, chocolate and biscuits", "[name] likes a vegetarian and sugar free diet", [name] likes two pillows on his bed at night", [name] only likes female carers and "[name] likes to wear Opium perfume" and "[name] likes their medication from a spoon".

Some care plans were less task orientated and more enabling in their focus. They contained information on medical conditions and how best to support a person to be more independent. One person's care record contained details regarding their multiple heath concerns. There were instructions for staff on how to support during personal care tasks and the need to support throughout the day and night. It also made reference to what the person was able to do for themselves on 'a good day'.

More robust records had been introduced in the last two months to record and monitor specific tasks such as repositioning and fluid intake. There were directions for staff as to how often a person needed to be positioned, to what part of their body they should be moved and the setting of their pressure relieving mattress if applicable. Records of interventions undertaken were complete and reviewed by a senior member of staff. Staff informed us "The supplementary records (repositioning, eating and drinking and weight monitoring charts) are much better, we're completing them all the time, we understand more now how important they are."

There was improved information on strategies to support emotional health or describe how low mood presented, signs and triggers. Other people were at risk of a urinary tract infection or constipation and there was advice for staff as to how to monitor for signs and symptoms and what actions to take for that individual. We saw that staff had followed this guidance and, for example, had tested a person's urine at a period when they had become more unsettled. There was information in care plans as to how provide catheter care such as monitoring fluid input and output, the positioning of the bag to avoid skin damage and it's emptying.

We established from medication records that some people had patches for the control of pain. Staff were able tell us for what condition the patches had been prescribed and this was detailed in their care plan along with a pain monitoring chart.

A number of social activities were provided including reading, listening to music on the radio, watching television and games. An activities co-ordinator was available on a number of week days but also on a Saturday morning. There were also regular trips out into the local community for lunch or to a garden centre. 'Active aging' was encouraged with an outside person attending to carry out exercises with the people who used the service. Staff had taken this on board and repeated these exercise on other days which people, we observed, enjoyed.

Complaints information was displayed in the foyer and people were able to find and access this. This advised people on how to contact the provider directly and gave the contact details and information about the role of the local government ombudsman and CQC. Compliments and complaints were recorded and addressed. We saw that responses had been made where concerns were raised and apologies offered where

appropriate.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been absent from the service since April 2018 and there was a possibility they may not return. It was evident from the minutes of staff and resident meetings that they found it difficult to accept the findings of the last inspection. Comments in minutes of meetings with staff and people who used the service included "[name] thanked everyone for their support during the aftermath of the CQC and subsequent report" and "[name] apologised for not spending time … but responding to the inaccuracies and CQC had taken up their time".

In the interim period, the Clinical Lead Nurse had taken on the management role and was working alongside the registered provider to ensure continuity in the running of the service.

At the last inspection, we noted that there was a history of continued noncompliance. These omissions had not been identified as part of the quality monitoring system within the service nor as part of the registered manager's on going monitoring of the care provided at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. On this occasion we found that the overall quality assurance systems had been reviewed and new processes being implemented. There remained a breach of the regulation as the effectiveness of this system was yet to be demonstrated.

A number of more robust audits had been introduced. A medication audit was regularly undertaken and had picked up on issues regarding recording and administration. Where mistakes had been made, these had been investigated and actions taken with staff concerned. However, this had failed to highlight the issues with creams, storage and risk detailed on this inspection.

Care plans and risk assessments were being rewritten but had not yet been audited to ensure that they were complete and accurate reflection of a person's needs.

There had been a failure to ensure that a schedule of checks was in place and implemented to ensure the safety of the premises and the safe recruitment of staff.

There was a service user guide in place. This included general information about the home including staffing levels, type of care provided and contact details of the provider. The service provided a Statement of Purpose which outlined the service to be provided and its mission. The service supports people that are under 65 but this was not reflected in the "service user bands" registered for the service with CQC. We noted that from our records that discussions about this matter had been on going with the registered provider since 2016 they had still not undertaken the required steps to rectify this.

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

The registered provider subscribed to an organisation that provided them with a comprehensive set of policies and procedures. They told us that although this had been in place throughout previous inspections, it had not been fully utilised. They were now implementing this guidance to introduce consistency and more

robust monitoring.

Following concerns in regard to mealtimes, a dining experience review was undertaken each week and any issues addressed and rectified. Further audits had been undertaken in regard to call bell response times. Where there had been a delay in response, this had been explored and a rationale provided. For example: staff had been assisting another person.
The registered provider and the clinical lead nurse had been participating in a Quality Improvement programme facilitated by the Clinical Commissioning Group and the Local Authority. They spoke to us about how this had improved their understanding of good governance and how this was now informing their on-going improvement delivery plan.

Following the inspection in September 2017, we placed a condition on the registered provider's registration that no admissions be permitted to the home without the prior written consent of CQC. This has been complied with and to date no new admissions had been made to the service.

Prior to the inspection, we reviewed the statutory notifications that the registered provider had submitted to the CQC. Notifications enable CQC to monitor any events that affect the health, safety and welfare of people who use the service and decide if we need to take any action. These had been received as required.

The registered provider's website was being reviewed at the time of the inspection and not available for viewing. However, the rating at the service was now conspicuous as it was printed in colour and at a minimum size of A4.