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The Old Farm House Residential 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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 7 and 8 September 2017 and was unannounced.

The Old Farm House Residential is registered to provide accommodation and personal care for up to 26 people. There were 24 people using the service during our inspection; who were living with a range of health and support needs, including diabetes and dementia. Accommodation is arranged over two floors with the majority of bedrooms having an ensuite facility, the service is fully accessible to those in wheelchairs or with mobility difficulties and the first floor is accessed by a passenger lift. The service had a large communal lounge available with comfortable seating and a TV for people and separate, quieter areas. There was a secure enclosed garden to the rear of the premises.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. A new manager had been appointed and had started the process for applying with the Commission for their registration; they were not present throughout the inspection. The deputy manager and provider were available throughout the inspection.

The previous inspection on 9 and 10 January 2017 found eight breaches of our regulations. The well led domain was rated inadequate and an overall rating of requires improvement was given at that inspection. The provider and registered manager were issued with a warning notice for a breach of regulation 17 of the Health and Social Care Act. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

At the last inspection the provider had not ensured actions designed to address risk had been followed through into practice. Falls risk assessments were not in place routinely even for those identified as prone to falls. Risk assessments for people's mobility were not followed in practice; staff did not know how to safely evacuate people in the event of an emergency. People's health care had not been managed effectively. Medicines had not been managed in a safe way. There was not sufficient numbers of staff deployed to meet people needs. Staff performance was not robustly monitored. Recruitment processes were not robust. People were at risk because there was a failure to ensure that all required servicing of equipment within the premises had been undertaken. Not enough was being done to ensure people's individual preferences around stimulation, activity and engagement were addressed. Staff did not have a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivations of Liberty Safeguards (DoLS); Audits had not effectively picked up concerns which we had found during the inspection.

The provider had taken some action to address the concerns raised at the previous inspection. However, further work was required to ensure risk to people's safety were further reduced specifically in relation to the management of falls, medicines, health and auditing processes.

Some areas of medicine management needed further improvement to ensure people received medicines in a safe way.

People at risk of falls had risk assessments in place. However, the provider had not always taken enough action to analyse incidents so further measures could be implemented to help reduce the number of falls people had.

There were enough staff to meet people's needs although the deployment of staff needed further improvement to ensure people were always responded to quickly when in need of support.

The provider had taken action to improve how people's health needs were monitored and responded to. However, further monitoring was required to ensure people's health was consistently supported and monitored.

The provider had taken action to meet the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, further training for staff was required to ensure they fully understood the requirements of the act.

One person could be verbally and physically challenging towards others. There was no behaviour guidance in the person's care plan to refer to and staff had not received any training in behaviour management. The majority of staff had received other mandatory training to effectively complete their roles.

The provider had improved their auditing process since the previous inspection which had mainly focused on the environment. There was better oversight of the service as a whole and the new manager had started to take steps to improve service delivery. Staff said they felt morale had improved by means of better communication and understanding about their roles. Staff said they felt more listened to. Further work was required in regards to auditing so improvement could be made in the areas highlighted during this inspection.

Employment checks had been made to ensure staff were of good character and suitable for their roles. Staff were trained in safeguarding and understood the processes for reporting abuse or suspected abuse.

Appropriate checks were made to keep people safe. Safety checks had been made regularly on equipment and the environment. People had individual personal emergency evacuation plans (PEEPs) that staff could follow to ensure people were supported to leave the service in the most appropriate way in the event of a fire.

People had choice around their food and drinks and staff encouraged them to make their own decisions and choices.

People were encouraged to remain as independent as possible. Where possible the consent of people was obtained and their views and preferences were respected. When people were in discomfort or distressed staff responded in a gently and in a caring way. Staff spent time talking to people in a meaningful manner.

Since the last inspection an activities person had been employed. Care plans had been reviewed and updated providing more person specific information about people's needs.

Complaints were recorded and responded to effectively. The manager had sought the views of people to make improvements to the care and support they received.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end 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 consistently safe.

Although accidents and incidents were recorded and audited to identify patterns, further analysis was required to reduce the likelihood of incidents repeating.

Risk assessments had not always been updated promptly.

Some areas of medicine management needed further improvement to ensure people received medicines in a safe way.

The deployment of staff needed further improvement although the number of staff was sufficient.

Safeguarding processes were in place to help protect people from harm. Staff understood the processes for reporting concerns about people's safety.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Further monitoring was required to ensure people's health was consistently supported and monitored.

Staff did not have a good understanding of the Mental Capacity Act 2005.

Most staff had received the majority of their mandatory training although further training and guidance in the management of behaviour would be beneficial.

People were involved in making decisions about their food and drink.

Is the service caring?

Good ●

The service was caring.

Staff respected people's privacy and encouraged them to make their own choices.

People moved freely around their home and had decorated their personal space in their preferred way.

Staff spoke to people kindly and treated them with respect and dignity

Is the service responsive?

Good ●

The service was responsive.

Care plans were person centred and contained information which was important to the person.

People were offered various activities within the service.

There was a complaints procedure available for people should they be unhappy with any aspect of their care or treatment.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

Audits and reviews of the service were conducted. Further analysis was required so better monitoring of risks to people could be achieved and action taken accordingly.

People's feedback was sought so improvements to the service could be actioned.

The manager had started to improve the service; staff had good attitudes and understood their roles well. Staff felt more listened to and included in decisions made about the service.

The Old Farm House Residential 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 7 and 8 September 2017 and was unannounced. The inspection was carried out by one inspector on both days. An expert by experience attended the inspection on the first day. The expert by experience had experience of caring for older people who may have dementia.

Before our inspection, we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about. The provider had not had the opportunity to complete a Provider Information Return (PIR) as they had not received this document before the inspection. 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 collected this information throughout the inspection.

We inspected the service, including the bathrooms and some people's bedrooms. We spoke with 16 people who lived at The Old Farmhouse Residential Home. We spoke with three relatives, six of the care workers, the cook, the activities person, the deputy manager and the provider. Before the inspection we received feedback from one healthcare professional.

We 'pathway tracked' seven of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care. During the inspection we reviewed other records. These included staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and

incident records, quality audits and policies and procedures.

Is the service safe?

Our findings

People spoke positively about the service. Comments included, "We are very well looked after here and feel safe as you like at all times of day or night" and, "We are always being told what to do in an emergency, whether we can remember to or not is a different matter".

At our inspection on 9 & 10 January 2017 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's medicines were not always managed safely: medicines which were not in a pre-packaged dosage system had not been dated upon opening. Some people were prescribed medicines to be administered when they needed them. These are called 'PRN' medicines. There was insufficient guidance in place for staff to know when these medicines should be administered and staff had not received refresher medicine training to update their practice. Although the provider had taken action to address the issues raised there were still areas of medicine management which needed to improve.

The deputy manager was unaware that additional PRN guidance had been implemented following the previous inspection. They initially told us there was no PRN information although they were in charge of the management of medicines. They later found a folder containing specific information about PRN medicines for individual people. This did not demonstrate information was referred to or readily available for staff. The provider said they had asked staff if they knew about this folder and not all staff were aware, they said they needed to do some further training with staff around this. Some medicines continued to be undated when opened, specifically eye drops and topical creams. Handwritten entries on medicines administration records (MAR) charts had not been double signed which was an area for improvement the visiting pharmacist had identified when they conducted an audit in July 2017.

There was a failure to ensure all aspects of medicine management were managed well. This is a continued breach of regulation 12 of the HSCA 2008 (RA) Regulations 2014.

Other areas of medicine management were satisfactory. There was good practice around processes for ordering, receipt, storage and disposal of medicines. The pharmacy who supplied people with their medicine conducted an audit in July 2017. Their report stated, 'It was very pleasing to see a vast improvement in medicines management within the home since my last visit'. A person said, "All my medicines are brought to me at the same time every day and that is a blessing that I don't have to worry about forgetting them any longer". Staff that administered medicines were trained to do so.

At our last inspection we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to people were not managed safely. There were no individual risk assessments for people who needed support with their mobility. People who were at risk of developing pressure areas had risk assessments in place. However, equipment intended to reduce the risk was not properly maintained, and this omission increased the risk of pressure areas developing. Falls risk assessments were not in place routinely even for those identified as prone to falls. Personal emergency evacuation plans (PEEPS) had been developed for people in the service but these did not offer staff enough

detail to make clear how they should evacuate people. Staff did not know how to safely evacuate people in the event of an emergency. Although the provider had taken action to address the issues raised there were still areas that needed further improvement.

People at risk of falls had risk assessments in place. However, the provider had not always taken enough action to analyse incidents so further measures could be implemented to help reduce the number of falls people had. For example, one person had an unwitnessed fall in July 2017 which had resulted in them being admitted to hospital. Their care plan and risk assessment had not been reviewed after the fall. The provider said, "There should be a sensor mat in place as long as the person has consented to this. An audit should have taken place after the fall and action to reduce taken. I will be asking questions as to why this was not done following the fall and hospital admission". During the inspection the person was asked if a sensor mat could be put into their room. (A sensor mat when stepped on triggered the call bell system which would alert staff if the person was mobilising in their room). Although staff said they regularly checked on this person this had not been recorded. An additional daytime observation sheet was implemented during the inspection.

Another person had several falls in 2017. There was a risk assessment in place and the person had been referred to the falls team but had not consented to treatment. This person had osteoporosis which is a condition that weakens the bones, making them fragile and more likely to break. Because the provider had not been analysing incidents more robustly they could not be assured that every practical measure had been taken to reduce the risk of the person falling again.

There was a failure to ensure a robust system was in place for the identification and mitigation of risks people experienced. This is a continued breach of Regulation 12 of the HSCA 2008 (RA) Regulations 2014.

At our last inspection we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff at peak times and peoples personal care needs had not always been met which had impacted on their dignity. Although the provider had taken action to address the issues raised further work was required to improve the outcomes people experienced.

We observed one occasion where a person was not responded to quickly when they called for assistance. We had to intervene and alert the provider as the person was distressed. The deployment of staff had not been well co-ordinated as staff had been on their break when this incident had occurred. At other times people were responded to quickly and call bells were answered promptly. The provider reviewed call bell waiting times to analyse if further work was needed to respond to people's needs in a timely way. A person said, "Yes the girls always come to help very quickly, as quickly as they can". Another person commented, "Sometimes you have to wait a while but they are only human and can't be in two places at once. I wouldn't say it is ever longer than five minutes though". The deployment of staff is an area which requires improvement.

The provider used a dependency assessment tool to determine the right number of staff that should be on duty to assist people. The provider said following the previous inspection they had introduced this tool which had helped them identify when additional staff were required. During the day shift there were four carers which reduced to three in the afternoon with two waking night. Additionally, a domestic assistant had been employed for four hours each morning which helped other staff focus on assisting people with their personal care needs. An activities person had been employed for two hours five days a week to improve opportunities of social stimulation and to avoid isolation.

One person needed a special air mattress to help prevent pressure wounds. These are set to people's weights to provide the best therapeutic effect. There was clear documentation that the mattress settings were checked on a daily basis although the mattress dial did not state specific weights but a dial ranging from soft to hard. We asked the provider how they ensured the mattress was on the right setting according to the person's weight. Although the provider had sought guidance from the engineer who serviced the mattress they could not be assured the mattress was set correctly as the equipment manual gave vague instructions. The person had not suffered any pressure damage to their skin; we do however recommend that the provider receives advice from the district nurse about the most appropriate setting for this person.

At our last inspection we found that the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from unsafe equipment and their safety was compromised. The provider had taken action to address the issues raised.

Appropriate checks were made to keep people safe and safety checks were made regularly on equipment and the environment. This included fire equipment, electrical installation, gas safety, wheelchair checks, checks on hoists and the passenger lift and water temperature checks. A business continuity plan (This is a plan of actions to be taken by the manager and staff in specific emergency situations) was in place in regard to a range of events that might stop the service from operating normally. This covered a range of eventualities so that staff would know what to do and could implement emergency procedures.

People had individual personal emergency evacuation plans (PEEPs) that staff could follow to ensure people were supported to leave the service in the most appropriate way in the event of a fire. Regular fire drills were conducted to practice the effectiveness of emergency procedures and staff said they regularly discussed the evacuation process with each other and with people to prepare for an emergency situation.

Employment checks had been made to ensure staff were of good character and suitable for their roles. References were obtained and Disclosure and Barring Services (DBS) checks made. These checks identified if prospective staff had a criminal record or were barred from working with vulnerable adults. Other checks made prior to new staff beginning work included health, employment gaps and appropriate identification checks.

Robust safeguarding, whistleblowing guidance and contact information was available for staff to refer to should they need to raise concerns about people's safety. Staff understood their responsibilities in relation to raising any concerns of abuse and understood the process they should follow. A staff member said, "I would go to the manager or go on the computer (where there is safeguarding information) or we could phone CQC".

Is the service effective?

Our findings

A person told us, "If I feel unwell they call for help immediately and I never have to worry".

At our last inspection we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had not always had their health needs met in a timely way. Although staff had raised concerns that people were unwell referrals to other healthcare professionals had been delayed without good explanation. Although the provider had taken action to address the issues raised there were still some concerns with how people's health was managed.

In July 2017 staff had recognised a person looked unwell and was not drinking fluids as they normally would. The person was taken to the hospital, when they were discharged from hospital measures had not been implemented to monitor their fluid intake. Their care plan, in relation to hydration had not been reviewed or updated since June 2017, before the hospital admission. We asked the deputy manager if the persons fluid intake was being monitored they said, "Following (persons) admission and discharge from hospital no fluid charts have been used but should have although we were writing in the daily notes 'encourage fluids'". Although the person was now drinking well action had not been taken to monitor this robustly. Other people at risk of dehydration had fluid charts in place to monitor their fluid intake. This is an area that requires improvement.

Other health needs were monitored and referrals made to health professionals when necessary. During the inspection one person displayed behaviours indicating they were in discomfort. They were unable to verbally explain what was causing them distress so their GP was contacted for further advice. Staff sat with the person and held their hand to comfort them.

At our last inspection we found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received training in MCA or DoLS, in how to implement the principles of the MCA 2005 into everyday practice and staff knowledge of this area was not sufficient. Applications to the authorisation DoLS office had not been made for people who met the criteria. Although the provider had taken action to address the issues there was still improvement needed, particularly in staff understanding of this area.

A person said, "I am always consulted before any decision is made about my care and I then discuss it with my son or he telephones to discuss things for me". 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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). The provider had assessed people's capacity and applied for DoLS authorisations for two people. We asked the deputy manager if a person who had fallen had capacity to consent to the use of a sensor mat in their bedroom, they told us the person did not even though an assessment in the care plan stated they had full capacity. The provider told us following the last inspection the person's sensor mat had been removed as there was confusion as to if the Act was being adhered to. During the inspection the person's sensor mat was reinstated, with their consent. The provider said they recognised this was an area that required further

improvement to ensure staff had the right knowledge and skills to meet the criteria of the legislation. This is an area which requires improvement. Other Peoples capacity had been assessed and people were not restricted when they had capacity to make their own decisions.

At our last inspection we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not consistently received training appropriate to their role, and this impacted on the care and support people received. Staff had to deal with some behavioural issues from time to time but had not received any training in behaviour management and de-escalation techniques to give them confidence when dealing with issues of this nature. A supervision schedule was kept of when staff had received supervision but this did not record all the staff currently employed as it had not been updated to take account of new staff. Although the provider had taken action to address the issues there were still some concerns with the training and guidance staff received.

One person could be verbally and physically challenging towards others. There was no behaviour guidance in the person's care plan to refer to and staff had not received any training in behaviour management. Although staff had a good understanding of how to respond positively to the person the lack of guidance and training could result in inconsistencies in how the person was supported at these times. This is an area which requires improvement. Following the inspection, the provider sent us a behaviour management plan to give staff guidance to support the person.

The majority of staff had received mandatory training. A staff member said, "Since the last inspection we have been given more training". A person told us, "The staff all know exactly what's what around here and what needs to be done. They are all very efficient and knowledgeable". Another person said, "The one thing that I can say with complete confidence is that the staff all know their jobs and make sure it is done jolly efficiently too". Further training in infection control, end of life care, and manual handling had been booked for September and October 2017. Staff were competency checked by the manager in moving and handling, medicines, and safeguarding. The provider said, "We identified some incorrect responses (safeguarding processes) and did some extra work to assure staff that raising safeguarding is everyone's business. We have reassured staff, which was a main concern, that raising a concern that is not then recognised as abuse is okay".

New staff were inducted and completed the Care Certificate. The Care Certificate was introduced in April 2015 and are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. Staff were encouraged to gain qualifications in health and social care while working at the service. 14 staff had obtained a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

Staff confirmed that they had supervision and the management were always available for support. Through supervision it could be identified if further performance management was necessary to help staff in particular areas they may struggle with. Supervision also gave staff the opportunity to identify any areas they wished to develop further or support they may wish to receive. A staff member commented, "I get regular supervision, any problems I talk to the manager. We've had lots of training, moving and handling, health and safety, and fire safety". Staff received annual appraisals to review their progress throughout the year and agree development plans for the following year.

People commented, "You couldn't get hungry around here even if you wanted to, the food is so good and plentiful", "We can have a snack or a drink at any time of day or night" and "We have a wonderful varied

choice of meals, usually only a choice of two for dinner but what more do you need. It's wonderful". The cook had a good understanding of people's individual dietary needs. The cook said, "A few people have fortified diets, we watch to see if people's health changes. If people are losing weight we weigh their food and keep a food chart and try to add additional calories". The cook went around to people each day to ask them what they would like for their meals. People were also given a survey to complete to feedback on the food and action was taken if people highlighted anything they did not like or wanted to be changed. Some people chose to take their meal in their rooms. Other people sat together and with staff in the dining room which was sociable and relaxed. People were offered second helpings and chatted over their meals with each other and staff.

Is the service caring?

Our findings

Peoples comments included, "The care is great here, it really is amazing how patient and caring all the staff are as we can be jolly troublesome I can tell you", "I am quite a private person really and they all know to knock loudly before entering my room and to wait for an answer and they do respect that" and "I don't get lonely like I did at home and I get so much care and attention I am now happy and living a proper full life now".

At our last inspection we found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We observed people's dignity was sometimes compromised by staff not having time to check their appearance. Some peoples clothing was inside out, unbuttoned and one person was unshaven although their care plan stated they liked a wet shave. The provider had resolved these issues which were no longer a concern at this inspection.

People were encouraged to remain as independent as possible. A person commented, "I can do all my own personal care and they help me to do it too but it makes me feel more independent doing it myself with just a watchful eye". Staff spoke to people in a respectful and caring way. We observed many examples of positive interactions between staff and people. Staff listened to what people said and spent time talking to people in an unhurried and interested way. People were treated with dignity and respect and there was good humour and rapport between people and staff.

People freely moved between their bedrooms and communal areas and in between meals; drinks, snacks (crisps and sweets) were left in communal areas for them to help themselves. A person said, "We can wander around wherever we want and sit wherever we want". A staff member was offering people various drinks and biscuits. The staff member waited for people to make their own choice and did not rush them. They said, "Which would you like, your usual or tea for a change? If you need anything shout for me".

Where possible the consent of people was obtained and their views and preferences were respected. People were asked for permission before staff entered their rooms and doors were closed when personal care or support was delivered. Throughout the inspection staff asked people what they wanted to do, eat, drink and if they wanted any support.

Some people that smoked sat outside in the garden with other people and staff, chatting and drinking tea. There was a relaxed atmosphere in the service; staff were not task driven and spent time engaging with people in a personal way. When people were in discomfort or distressed staff responded in a gently.

People were able to bring personal possessions important to them to decorate their bedrooms. One person told us they liked to stay in their bedroom and 'people watch'. They said, "I don't like crowds, I like my own company. You couldn't pay me a million pounds to go to that barbeque. Staff come quickly when I call, they drop in to say hello. Staff are lovely I have no problems".

No one at the service was considered to be in need of end of life care at the time of our inspection. The

provider had booked end of life care training for staff on 18th and 28th September 2017. Although there was basic information in some peoples care files regarding their end of life wishes information did not provide enough specific detail to demonstrate person centeredness around this sensitive area. We would recommend that the provider/manager seek information from a competent source about establishing end of life wishes for people and the use of end of life care plans.

Is the service responsive?

Our findings

A person said, "I am not very mobile anymore but sometimes I get wheeled to the shops if I feel like a little outing". Another person told us, "I do not like joining in with activities but the activities person will come and find me and give me a puzzle or a crossword or something she knows I will enjoy".

At our last inspection we found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no established programme of activities on a week to week basis that people could choose to participate in. There was no specific budget for activities and no staff member appointed to take on the role to facilitate activities. The provider had taken action to address the issues raised.

Since the last inspection an activities person had been employed who people and staff spoke about positively. During the inspection the activities person offered people an activity of indoor gardening. Some people said that they preferred their own company and would not participate in activities so the activities person spent time with them in their rooms. A person said, "I am not a great one for group participation but sometimes if there is something going on in the lounge like a sing song I can't resist and join in". Another person told us, "I value my own space and sometimes stay in my room but the activities lady brought some seeds in for me to plant and they have come on leaps and bounds".

A weekly activities planner was located in the lounge which people could look at to decide which activities they wished to join in with. Pet therapy, a dancing show, individual room visits, a pamper morning and tea with a toddler and a sing along had been arranged for the forthcoming week. The activities person said, "Not everyone comes out for activities. I split my time with people. I do hand massage, sing alongs. We've made corn dollies, lavender bag and have painted".

We observed staff frequently sit with people and talk to them in an unhurried way about their interests. Staff said since the domestic assistant had been employed they had more time to spend with people. A staff member said, "Now we have more freedom, now we have employed an activities person it's fantastic. It's very hard to encourage residents but just having one to one chats with people is much better". The service had hosted a garden party and barbeque in the summer and pictures of people's birthday celebrations were displayed in the foyer of the service.

At our last inspection we found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Records viewed showed care plans to largely be made up of a series of statements about the person with little detail to guide staff in offering a personalised support in keeping with each person's needs wishes and preferences. The provider had taken action to address the issues raised.

Since the last inspection care plans had been reviewed and updated providing more person specific information about people's needs. Guidance information covered areas such as personal hygiene, communication, nutrition, fluid intake, medication, oral care and skin integrity. There was also more specific

information about people's preferences in relation to social interest and hobbies, sleeping patterns, spiritual, cultural, and religious preferences.

Before people were admitted into the service the manager or deputy manager gathered pre-admission information to inform the care package and assess if the service were able to meet the person's individual needs. Pre-admission information covered people's basic health needs as well as information which was important for their wellbeing. Staff said they felt confident they could meet the needs of the people admitted into the service. A staff member said, "Pre-admission is much better now, more thorough to ensure staff can meet people's needs and we take the right people. Before the assessment was quick. Staff are more informed and communicated with".

A relative said, "We have honestly never had any reason to complain about Mum's care. Mum is extremely content. They are saints the way they look after her they really are". Complaints were recorded and responded to effectively. When complaints were received a response was given to the complainant to inform them how their complaint would be handled. The manager investigated complaints and recorded their findings. The manager used complaints to learn from mistakes and created action plans so complainants could be satisfied their concerns had been listed to and acted on. There were no ongoing recorded complaints at the time of inspection.

Is the service well-led?

Our findings

All the relatives we spoke with were complimentary of the service provided to their family member. A person told us, "We often see her (the manager) around the home and feel free to chat with her whenever we want or feel we need to". A relative said, "I can be rest assured that if I have any concern what so ever about Mum's care I will be listened to and it will be acted on immediately and satisfactorily but really there is nothing to report". A person said, "All the staff here are very approachable and they all, with no exception, will go out of their way to help if they can".

At our last inspection we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Leadership of the service was poor and people's needs had not been consistently met. The service did not have an effective quality assurance system in place to drive improvement in a sustained and proactive way. Apart from medicines audits there was an absence of any other audits. The absence of such audits meant that the registered provider could not assure themselves that service quality in all areas was being met or maintained. Although the provider had taken action to address the issues raised there were still some areas of quality assurance which needed to improve.

The provider had improved their auditing process since the previous inspection which had mainly focused on the environment. Audits now covered a wider range of areas including, incident and accidents, health and safety, infection control, staff training, medicines, and manager reports. Further work was needed to ensure audits robustly identified areas of further improvement. For example, the management of falls risks, medicine practice and management of people's health specifically in relation to dehydration which we had identified as areas in need of improvement during this inspection.

The failure to ensure systems and processes were in place to assess, monitor and improve the quality of the service and the failure to assess, monitor and mitigate risks to people is a continued breach of Regulation 17 of the HSCA 2008 (RA) Regulations 2014

The provider had not ensured that the Care Quality Commission was notified appropriately and in a timely manner regarding one incident where a person was injured and admitted to hospital. The provider had not been aware about specific incidents being notifiable to the Commission, during the inspection they obtained guidance from the CQC website regarding the statutory notifications they should submit. Other notifiable incidents had been notified correctly by the manager. This is an area that requires improvement.

Although the provider had displayed their latest rating at the premises as required, they had failed to display their latest CQC inspection report rating on their website which is a legal requirement. We asked the provider to address this which they did during the inspection by deactivating their website which they said they had been unable to update.

Since the previous inspection the registered manager had left and a new manager had been appointed. The new manager was in the process of applying for their registration with the Commission. The new manager

was not present throughout the inspection but staff spoke positively about the changes they had begun to make at the service. Staff said they felt more consulted and included and understood their roles and responsibilities more. Staff said that there was good team support and this made them feel supported and listened to. The atmosphere within the service on the days of our inspection was relaxed, open and inclusive. The language used within records reflected a positive and professional attitude towards the people supported, and this was reflected in staff practice observed throughout the inspection. A staff member said, "I love this job and I love this place to work in, it is the most incredibly rewarding and enjoyable job to have the pleasure of doing".

The manager had sought the views of people to make improvements to the care and support they received. For example, a person had complained to the manager that their newspaper had arrived late and had been read before they received it. The manager took action to prevent this from happening again and reviewed the situation with the person after two weeks which the person reported back had improved and they were now happy.

On another occasion a person had feedback their food was not always hot when they received it. The manager spoke to the kitchen staff to make them aware and instruct them to place covers over the person's food while it was transported to retain its heat. The situation had been resolved. A person said, "There used to be resident meetings I believe but then she (the manager) thought it was more productive to see us individually and ask our opinions that way". Another person said, "They always ask for my opinion and what I think about living here and if there is anything I would like changed. My answer is always the same; I am happy and content and would not change a thing".

The provider said they had recently issued surveys to relatives which they would analyse once they had a sufficient number returned. Staff had regular meetings to discuss what was going well in the service and what could improve. The manager used this as an opportunity to acknowledge when staff had performed well as well as highlighting what could have gone better. In the meeting held in June 2017 the manager had informed staff a staff member would be tasked with investigation and monitoring falls. The minutes from the meeting said, 'Staff will investigate how, why and how to prevent the resident from falling again, this folder will be kept alongside the accident /incident forms. Staff discussed this new role and everyone felt it should be in place'. Although this had been highlighted a staff member had not taken up this role which would have been of benefit to the auditing process to reduce repeating incidents of preventable falls.

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 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure systems and processes were in place to assess, monitor and improve the quality of the service and a failure to assess, monitor and mitigate risks to people. Regulation 17 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>There was a failure to ensure a robust system was in place for the identification and mitigation of risks people experienced. Regulation 12 (1) (2) (a) (b).</p> <p>There was a failure to ensure all aspects of medicine management were managed well. Regulation 12 (2)(g)</p>

The enforcement action we took:

The provider was issued with a warning notice for regulation 12.