Silk Healthcare Limited

Belvedere Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection at Belvedere Manor on 13, 14 and 15 June 2018.

Belvedere Manor 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 is purpose built and accommodates 84 people on three floors known as Village, Woodlands and Garden suite. Woodlands suite specialises in providing care for people living with dementia. At the time of the inspection, there were 71 people accommodated in the home.

The service was managed by a registered manager. 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 the last inspection carried out on 6, 7, 8 and 13 November 2017, we asked the provider to make improvements to improve the assessment of staffing levels, the management of risks, the management of medicines and the implementation of the Mental Capacity Act. Following the inspection, the provider sent us an action plan and told us they would make the necessary improvements by April 2018.

During this inspection, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 and one breach of the Care Quality Commission (Registration) Regulations 2009. We found continuing shortfalls in the management of medicines, the way risks to people's health, safety and welfare were managed and the application of the Mental Capacity Act. In addition, we identified further shortfalls in the staff recruitment process and the governance arrangements as well as a failure to submit some statutory notifications.

We are considering what action we will take in relation to these breaches. Full information about the CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

At the last inspection, the service was rated as overall 'requires improvement', at this inspection the rating had deteriorated to overall 'inadequate'.

Safeguarding adults' procedures were in place and staff spoken with understood how to safeguard people from abuse. However, staff failed to recognise a serious occurrence was a safeguarding incident and delayed completing an incident report. Whilst there was evidence to indicate the circumstances of the incident had been investigated there was no evidence seen to confirm the incident had been reported under safeguarding adults' procedures.

We saw people's care files contained individual risk assessments, however, not all risks had been assessed and recorded and consistent action had not always been taken to mitigate risks.

We found serious shortfalls in the recruitment of new staff. Prior to the inspection, we asked for a list of all new members of staff along with details of a specific employment check. The list was confirmed as accurate and correct by the area manager and the registered manager. During the inspection, we found appropriate checks had not been carried out for a member of staff who had been omitted from the list. Whilst the registered manager explained this was an oversight, it meant the information submitted was inaccurate and misleading.

We found dependency profiles had been completed for all people living in the home to help determine the level of staffing. However, people, staff and relatives continued to express concern about the number of staff on duty.

We found there were continued shortfalls in the management of medicines. This included gaps in record keeping and a lack of guidance for staff.

Whilst staff told us they had completed appropriate training, the provider was using four different systems to manage and monitor staff training. This meant we were not able to assess the training completed by staff during the inspection. The registered manager offered to send us an up to date training matrix, however, this was not received. Not all staff had completed induction training when they commenced work in the home and not all staff had received the number of one to one supervisions advised by the provider's policies and procedures.

The provider was not working within the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected.

Whilst people had access to healthcare services, we found staff had not responded in a timely way to GP advice in respect to one person's health.

People and relatives told us the staff were caring and kind. However, there was limited evidence to demonstrate people had been involved in the care planning process. This meant people were not given the opportunity to have direct input into the planning of their care.

Each person had an individual care plan, however, we noted some care plans contained conflicting information, which could impact on the delivery of care.

There was a complaints procedure in place and we saw evidence complaints had been investigated and responded to. However, not all complaints had been recorded in a central log, which meant concerns were not considered as whole in order to identify any patterns or trends.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our

enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health, safety and welfare were not always assessed and mitigated.

Medicines were not always managed safely.

The provider had failed to obtain and complete regulatory checks for all new members of staff. This meant people could not be assured staff were suitable to work in a care environment.

Whilst dependency profiles had been developed to help determine the staffing levels, people, relatives and staff continued to express concerns about the number of staff on duty.

The provider had a policy and procedure on safeguarding vulnerable adults.

The home was clean and hygienic in all areas seen.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not acting in accordance with the Mental Capacity Act 2005. This meant people's rights to freedom and independence were placed at risk.

Staff told us they received appropriate training. However, some staff had not received induction training when they started work and had not had a one to one supervision.

People had access to healthcare services; however, advice was not always followed in a timely manner.

People had mixed views about the quality of the food. Staff completed food and fluid charts all together after meals, which meant there was an increased risk of inaccurate recording.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us the staff were friendly and caring and we saw this in our observations.

Relatives were made welcome in the home, however, they expressed concerns about the turnover of staff and the consistency of care.

People were not always involved in the care planning process.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Each person had an individual care plan; however, some plans contained conflicting information.

Whilst there was complaints procedure in place, not all complaints were recorded in a central log. This meant concerns were not considered as whole in order to identify any patterns or trends.

People and relatives told us the frequency and quality of activities had declined since the last inspection. A new activity coordinator had been appointed, but had not fully started work in the home.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems and processes in place to monitor and improve the service or assess, monitor and mitigate risk.

Belvedere Manor

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.

An unannounced comprehensive inspection took place at Belvedere Manor on 13, 14 and 15 June 2018. The inspection was carried out by two adult social care inspectors, two medicines inspectors, an assistant inspector and expert by experience on the first day, two adult social care inspectors and an assistant inspector on the second day and two adult social care inspectors on the third day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In preparation for our visit, we considered the previous inspection report and information that had been sent to us by the local authority's contract monitoring team. We also checked the information we held about the service and the provider. This included statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

Prior to the inspection, we received a significant number of concerns about the operation of the service from staff and relatives. Whilst some concerns were being investigated by the local authority's safeguarding team, we analysed the information and incorporated the themes into the planning of this inspection.

The provider was not asked to submit a Provider Information Return. This is information we ask providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection visit, we spent time observing how staff provided support for people to help us better understand their experiences of the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience people who could not talk to us.

We spoke with 12 people living in the home, ten relatives, five members of staff, the administrator, the chaplain, the chef, the music therapist, the area manager and the registered manager. We also spoke with a visiting healthcare professional and a social care professional.

We had a tour of the premises and looked at a range of documents and written records including a detailed examination of seven people's care files, seven staff recruitment files and staff training records. We also looked at a sample of people's medicines administration records, the policies and procedures, complaints records, accident and incident documentation, meeting minutes and records relating to the auditing and monitoring of service provision.

Inadequate

Is the service safe?

Our findings

At the inspection in November 2017, we were concerned because people were at risk from unsafe care and treatment. We found people's medicines were not always managed safely; the provider had failed to demonstrate sufficient staff were deployed in the home and risks to people's health and safety were not fully mitigated. Following the visit, the provider sent us an action plan to tell us how they would make improvements to the service. At this inspection, we found some improvements had been made to the system used to determine the number of staff deployed in the home, but the management of medicines and risks to people's health, safety and well-being continued to require improvement to meet the regulations. We also identified additional shortfalls in the way new staff were recruited and managed.

We saw senior staff members had carried out a number of assessments for each person to identify risks to their health and safety in relation to their care needs. For example, some people had risks in relation to skin care and the development of pressure ulcers, nutrition, and mobility. However, we found not all of these had been completed in sufficient detail to ensure risks were minimised.

According to an accident report, a person was found on their bedroom floor with 'no sensor mat switched on'. This meant the staff would not be alerted if the person experienced a fall. We looked more closely at this situation and noted, the person's risk assessments and care plans did not refer to the use of a sensor mat to detect movement. This meant staff may not have been aware a sensor mat was in use to support this person's needs. Whilst there were records made of the sensor mat checks, we found the records were sporadic, with some days four checks made and other days none. We asked two senior staff about the frequency of sensor mat checks. They both gave different responses. One senior member of staff told us this issue had been discussed in a team meeting; however, they were not aware of any written guidance for staff to follow.

This situation gave us cause for concern as we found people had experienced falls with sensors switched off at our previous inspection. We were given an action plan following our last visit, which gave assurances that sensor checks would be undertaken every hour to ensure they were switched on. We found no evidence to indicate systematic checks had been implemented.

We were told prior to the inspection; one person was at risk from consuming excessive amounts of condiments. The senior staff on the person's suite was aware of the risks and had made some arrangements to mitigate the risk, however, the person was at increased risk when visiting other areas of the home. The registered manager was not aware of the risks and there was no risk assessment on the person's file in order to provide staff with guidance on how to mitigate the risks to the person's health and safety.

On looking at the incident records we found staff had failed to complete an incident form at the time of a serious occurrence at the home. According to the records seen, the form was completed retrospectively 18 days later and although a social worker was contacted in relation to the person's mental health needs, there was no evidence the circumstances of the incident had been reported to the local authority under safeguarding adults' procedures. The delay in recording a serious incident meant the person remained at

risk and the risks to others living and working in the home may not have been appropriately assessed and mitigated.

People were at risk from unsafe care because the planning and delivery of care was not always carried out in accordance with the Mental Capacity Act 2005. There was no evidence seen to demonstrate people were involved in managing risks that may affect their safety. Further to this, we noted restrictions had been placed on one person's liberty, which significantly limited their control over their life. This placed the person's legal and human rights at risk.

These concerns constituted a continued breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was because there were issues which medicines documentation and records. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection, we saw improvements had been made but found further issues.

Medicines were stored securely and in line with manufacturer's guidance on all three floors of the home. Daily controlled drug stock counts were being recorded but balances were not checked to ensure the stock was correct. Controlled medicines administered by district nurses had not been recorded in the controlled drug record book so records were inaccurate. This is not in line with legislation and meant there was a risk these medicines could be misused.

We looked at medication administration records (MAR) for 16 people. There were no gaps in administration indicating that people received medicines as prescribed, however we noted during the inspection, the morning medicines round was not completed until 11.30am. This may result in some medicines being given too close together. There were handwritten medicines on the MAR had not been signed by two staff, which helps to prevent mistakes. We checked a sample of medicines stock levels, which were correct.

Some people were prescribed medicines to be given 'when required'. Additional information to guide staff to administer these medicines safely was detailed and regularly reviewed. However, some instructions were missing. Some people were prescribed pain relieving medicines that require a minimum time interval between doses. The time of administration was not recorded to ensure a safe gap between doses.

We looked at one person's record who received their medicines disguised in food or drink. We saw documentation that this was in their best interest and information provided from the GP to instruct care staff how to administer each medicine without reducing its effectiveness. This process had improved since the last inspection.

Some people were responsible for administering their own medicines. We saw that risk assessments were in place to ensure these people were safe. We spoke with one person about their medicines and they had no issues. The person kept their medicines in a drawer in their bedroom but this was not locked. This meant that they were not stored securely and could be accessed by other people.

During the inspection, we saw one person had not received two of their regular inhalers for three days. Staff had recorded that the inhalers were not available; however, we found one inhaler in the person's bedroom. We raised the issue with staff who then arranged a supply with the pharmacy.

For medicines that staff administered as a patch, there was no system in place to record the site of application; this meant we could not be sure the patch position was rotated in line with the manufacturer's guidance to prevent side effects. Some people were prescribed topical preparations for example creams and ointments. Body maps were in use to guide staff where they should be applied, but these were not always completed. This meant staff did not know where to apply the cream or ointment. Some residents were prescribed a powder to thicken their drinks to assist with swallowing difficulties. Information on fluid consistency for each person was not available for all staff responsible for making drinks. Residents are at risk of choking if drinks are not given at the right consistency.

One person regularly visited family away from the home at weekends. Staff told us how these medicines were managed. However, the provider did not have a procedure in place for staff to follow. In addition, there was no risk assessment in the person's care plan which meant the provider could not be assured that it was safe for this person to take medicines properly away from the home.

We looked at three staff records, which showed they had been trained and assessed on the safe administration and handling of medicines. The registered manager told us that 17 staff had undergone medicine competencies in the last 12 months. Monthly medication audits were being completed and appropriate actions were being recorded to rectify any issues found.

The issues with controlled drugs, administration records and missing medicines meant there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

All registered services are required to carry out a range of pre-employment checks before new staff start work. This is to ensure all staff are suitable to work with vulnerable adults. Prior to the inspection, we received information about the lack of regulatory checks. We asked the registered manager for assurances and she confirmed staff would not be permitted to start work without the necessary checks. During the visit, we checked seven staff files and found shortfalls in the checks and documentation on all files. For instance, according to the records seen, one member of staff had not completed an application form or provided a full history of employment. We also found two members of staff had commenced work in the home without a criminal records check. One member of staff had a risk assessment in place, however, this was inappropriate and contrary to regulation, given their criminal records check had not been returned. This meant there was the potential for vulnerable people to be exposed to unsuitable staff.

The provider had failed to operate an effective and robust recruitment and selection procedure. This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection, the provider had failed to demonstrate sufficient staff were deployed in the home. During this inspection, we noted dependency profiles had been completed for each person living in the home and the scores had been used to determine the number of staff, as well as activities and people's appointments. However, people, their relatives and staff continued to express concerns. For instance, one person told us, "Sometimes, I can ask them for help and they take ages to come, by which time I have wet myself"; the person added that they felt "awful" about this situation. At 2.50 pm on the first day of the inspection, a member of staff told us they had only managed to support one person with personal care following lunch and none of the staff had taken any breaks. This meant the staff felt stretched and focused on tasks rather than on person centred care and support. On the second day of the inspection, an extra member of staff was placed on this suite and staff told us this had made a big difference to how care was being delivered.

We looked at how people were protected from abuse, neglect and discrimination. We found there was a safeguarding adults' and whistle blowing policy and procedure in place and information was displayed in the reception. Staff spoken with during the inspection understood their role in safeguarding people from harm and told us they had completed relevant training. They said they would report any incidents of abuse to the management team and were aware they could take concerns to organisations outside the service if they felt they were not being dealt with.

We saw the staff had followed guidance issued by the local authority and had completed rationale forms, which set out the reasons why they had not reported some incidents under the safeguarding adults' procedures. However, it was unclear which incidents had been reported. Following the inspection, we therefore asked the provider to submit a list of all incidents reported under vulnerable adults safeguarding procedures since the last inspection.

We noted records were kept in relation to accidents that had occurred at the service, including falls. We noted the records were checked by the registered manager. The registered manager had also carried out an analysis of accident information in order to identify any patterns or trends.

General risk assessments had been carried out to assess risks associated with the home environment. These covered such areas as fire safety, the use of equipment, infection control and the management of hazardous substances. We noted arrangements were in place if an emergency evacuation of the home was needed. People had personal emergency evacuation plans (PEEPs) which recorded information about their mobility and responsiveness in the event of a fire alarm. We saw there was a business continuity plan in place to respond to any emergencies that might arise during the daily operation of the home. This set out emergency plans for the continuity of the service in the event of adverse events such as loss of power or severe weather.

We checked the arrangements in place for the maintenance of the premises. We noted a maintenance officer was employed to carry out routine maintenance and repairs. We saw records to demonstrate regular checks were carried out on the fire systems, water temperatures, call points and equipment, such as hoists and bedrails. The electrical and gas safety certificates were in date and we noted appropriate arrangements were in place for servicing the fire systems including the fire extinguishers.

We saw the home was clean and hygienic in all areas seen. Staff hand washing facilities, such as liquid soap, paper towels and pedal operated waste bins had been provided in all rooms. This ensured staff were able to wash their hands before and after delivering care to help prevent the spread of infection. Staff were provided with appropriate protective clothing, such as gloves and aprons. There were contractual arrangements for the safe disposal of waste. We saw staff had access to an infection prevention and control policy and procedure and noted an infection control audit was carried out in the home every six months. The provider employed a team of housekeeping staff and regular checks were carried out of the environment, mattresses, slings and cushions.

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).

At our last inspection in November 2017, we found that whilst assessments had been carried out to assess people's mental capacity, we found no evidence had been added to explain how outcomes had been reached. We also found conflicting information in people's care files in relation to their mental capacity. This meant the provider had failed to act in accordance with the MCA and people were at risk of having their rights and liberties restricted unlawfully. This was a breach of legal requirements. Following the inspection, the provider sent us an action plan, which stated the necessary improvements would be completed by April 2018. At this inspection, we found limited progress had been made.

On looking at people's care records, we again found conflicting information in relation to people's capacity to make decisions. For instance, we noted one person's consent and capacity care plan stated they had 'been assessed as lacking having capacity' and they 'were no longer able to retain information or make informed decisions'. However, information in their communication care plan stated, the person 'has been assessed as having full capacity' and 'can make all decisions independently and consent when needed'.

Similarly, we noted one person was involved in an incident. A report completed following the incident states, 'resident fully aware' of the reasons for their actions. However, the person's consent and capacity care plan states they had 'been assessed as lacking capacity to make informed independent decisions'. Despite their plan stating they had 'no diagnosed impairment', we noted a DoLS application had been made to the local authority on the day of the incident and they were temporarily moved to a different area of the home, which was locked. There was no evidence seen of what action the staff took when they realized the incident had occurred. The person was able to fully recount the incident at the time of the inspection and told us, "I think they have lost confidence in me." This situation gave us concerns about the level of understanding of the MCA and related regulations as well as the impact this had on people's right to freedom and independence.

We asked the registered manager for information about the number of DoLS submitted to the supervisory body. We were given a folder, which indicated four DoLS had been authorised and 18 applications had been submitted for consideration. However, there was no information on the file about the person referred to above.

Our findings demonstrated the provider had not acted in accordance with the MCA. This was a continued breach of Regulation 11 (3) of the Health and Social Act (Regulated Activities) Regulations 2014.

We looked at how people were supported to maintain their health. We found all people were registered with a GP and had access to other healthcare professionals such as a chiropodist, optician, speech and language therapist, physiotherapist and the district nursing team. We spoke with a visiting healthcare professional during the inspection, who told us they had no concerns about people's care. Since our last inspection, information had been added to people's care plans about their specific medical conditions. This helped staff to have more insight into how people's healthcare needs impacted on their daily life.

On looking at one person's care records, we noted a GP had requested a sample of the person's urine due to a suspected urinary tract infection on Monday 11 June. However, the sample had still not been sent by the morning of Thursday 14 June. This meant the person could have experienced unnecessary pain and potential treatment could have been delayed. The registered manager confirmed the sample had been submitted later on 14 June, three days after the original request.

We looked at how the provider trained and supported the staff. Whilst staff spoken with told us they had received appropriate training, we were unable to check the training records because there were four systems in operation. This meant we were unable to ascertain if staff had completed relevant training. The registered manager offered to send us the training matrix when it had been compiled from the various systems. However, the matrix was not received at the time of writing this report.

There were arrangements in place for the induction of new staff, which included an initial orientation to the service, familiarisation with the organisation's policies and procedures, completion of the provider's mandatory training and the Care Certificate. The Care Certificate aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. However, according to the staff records seen three staff had not completed an induction when they commenced work in the home. Induction training is important to enable new staff to learn about the values and culture of the organisation as well as what is expected of their role.

Although staff told us newly appointed staff usually shadowed experienced staff for a week, we observed a new member of staff was asked to support a person to a healthcare appointment. We enquired further about this situation, as the new staff member was unfamiliar with the person's needs. This resulted in the arrangements being changed.

Following the last inspection, we were given an action plan devised by the provider which gave assurances that the induction process would be adapted to meet each new member of staff's individual needs and capabilities. We saw no evidence during this inspection to demonstrate this work had been completed and implemented.

Staff told us they were offered the opportunity to have a one to one supervision with their line manager. This process allows staff to discuss their role, any concerns and their future training needs. However, when we checked a sample of the staff files, we found there were no records to demonstrate three members of staff had received a supervision since they commenced work in the home. We observed the supervision form stated staff should receive six one to one supervisions a year.

Before the inspection, we received concerning information about the quality of the food provided. During the inspection, we found people had mixed views about the food. For instance, one person expressed a dislike for the food and told us certain foods were served to a very thick consistency; however, other people said they enjoyed the meals. For instance, one person said, "The food is excellent! I should know because I like my food."

We observed the lunchtime arrangements on all three suites on the first day of the inspection. We noted improvements had been made on Woodlands and Garden suites. People were supported to sit at the table a few minutes before the meal was served and all people were offered a choice of food at the point of serving. This allowed people to make an informed choice based on what was offered. We noted there was a cheerful atmosphere and people were encouraged in a gentle and patient manner to eat their food.

People's preferences with regard to food, along with any allergies or professional guidance were recorded and shared with the catering staff. This helped to ensure people received nutrition that met their needs and reflected their likes and dislikes. The registered manager informed us considerable work had been carried out to improve the catering arrangements and food standards were now much better. This had resulted in a recent five star food hygiene rating.

We noted nutrition and hydration risks were assessed and people were weighed at regular intervals. However, although food and fluid charts were maintained in line with identified risks, we noted the staff completed all the records together after meals. This meant the records were reliant on staff memory and there was an increased risk of inaccuracies.

We noted one person's uneaten lunch was still in their bedroom at 3 pm. The person's relative was present in the room and although they had asked to see their family member's food and fluid monitoring chart, this was not forthcoming. Hence, they were concerned about how much they had eaten and drunk. The relative told us, "The problem is they don't realize they are looking after very precious people."

We noted that technology was used to support people living in the home. There was Wi-Fi available throughout the building to enable people to use the internet on their own devices. In non-emergency medical situations, staff sought advice via Tele-medicines. This system enabled staff and people to contact and talk to medical professionals at a local hospital using a computer. Different types of sensors were in use where people had been assessed at high risk of falls and various interactive devices were used as part of the social activities.

Before a person moved into the home, a representative from the management team undertook a pre admission assessment to ensure their needs could be met. We looked at completed pre-admission assessments and noted they covered all aspects of people's needs. We were assured people were encouraged and supported to spend time in the home before making the decision to move in. This enabled them to meet other people and experience life in the home.

We looked at how people's needs were met by the design and decoration of the home. We found all areas of the building were decorated to a good standard. There was an interactive picture wall on Woodlands suite and memory boxes had been installed next to people's bedroom doors. The memory boxes enabled people to display photographs and small items of personal importance to help them recognise their room. However, we noted there was a lack of general signage to help people orientate themselves round the building. The registered manager told us signs were on order and were due to delivered shortly.

Requires Improvement

Is the service caring?

Our findings

People and relatives spoken with made mostly positive comments about the approach taken by staff. For example, one person told us, "The staff are very nice" and another person commented, "The staff are magic." Similarly, a relative said, "The staff at ground level are great" and another relative told us, "[Family member] is so well looked after. The care staff are kind, respectful and really nice. I can't ask for more than that." However, relatives also commented about the consistency of care. For instance, one relative said, "I am so concerned about why staff are leaving" and another relative told us, "There is a big staff turnover. It causes real anxieties for people and families." We noted a number of staff had recently left the home and we saw their resignation letters during the inspection.

Relatives spoken with confirmed there were no restrictions placed on visiting and they were made welcome in the home. We observed relatives visiting at various times throughout the days we were present in the home. Many relatives and people living in the home met up in the coffee bar area and this resulted in a pleasant cheerful atmosphere.

At the last inspection, we noted there was limited evidence to demonstrate people had been involved in the care planning process. During this inspection, we saw care plan documentation had been reviewed, however, we found little evidence to indicate people were actively involved in the planning of their care. This is important to ensure the staff are aware of people's preferences and how they wish their care to be delivered. We also noted a key worker system had not been embedded as part of culture of the home. This is a system whereby people using the service are linked to a named staff member who has responsibilities for overseeing aspects of their care and support. This meant there was a lack of close oversight of people's needs and wishes, which resulted in shortfalls. For instance, staff failed to act on a GP's advice for three days. This meant the person could have experienced unnecessary pain and potential treatment had been delayed.

The staff were knowledgeable about people's individual needs, backgrounds and personalities, however, they told us they didn't always have time to read people's care plans. This meant they relied on the information given during daily handover meetings. We looked at a sample of handover records and noted several different formats were used. We noted that the majority of records referred to people's needs in a respectful way. However, one record suggested a lack of understanding of one person's needs. We discussed this issue with the registered manager who agreed to discuss the record with the member of staff concerned. We also noted one handover record had not been completed, it was therefore unclear what information had been relayed to staff about people's health and welfare.

People spoken with told us the staff respected their dignity and privacy. We observed the majority of staff ensured personal care interventions were carried out behind closed doors in the person's bedroom or bathroom. However, we observed staff supporting one person to have a shave in the lounge with several other people present in the room.

Staff were aware of the importance of maintaining and building people's independence as part of their role.

One staff member told us how one person had regained their mobility after a period in hospital. Reflecting on the person's achievement, they said, "She doing so well. It's wonderful to see, she's a real inspiration." Other staff spoke warmly and positively about their work and the people they cared for. For instance, one member of staff said, "We have really good teamwork. We want to do our best for people."

People were able to express their views as part of daily conversations, residents' meetings and an annual customer satisfaction questionnaire. We saw minutes of the meetings and the results of the satisfaction survey during the inspection.

People were provided with appropriate information about the home in the form of a brochure and service user guide. There was also information about local advocacy services in the entrance hall. There were secure arrangements in place for the storage of personal files.

The provider employed a chaplain, who offered people, staff and relatives with spiritual and emotional support. Relatives spoken with particularly enjoyed attending a regular meeting at a venue outside the home. The meeting allowed them the opportunity to discuss their thoughts and feelings in a safe setting.

Requires Improvement

Is the service responsive?

Our findings

People spoken with told us they were able to follow their own routines and preferred activities. However, people also said the staff were very busy and did not always have sufficient time to respond to their needs. This view was shared by a relative, who told us, "When [family member] wants to use the toilet, they come when they are free, but sometimes they are not available and then they have accidents." Staff members spoken with on the first day of the inspection, also told us they were not able to respond to people's needs in a timely way. This situation was rectified on the second day of the inspection.

All people had an individual care plan based on their assessment of needs. We noted that the care plans were printed on yellow paper so information could be accessed quickly within people's files. We looked at seven people's care plans during the inspection and noted the plans were split into sections covering consent and capacity, mobility, falls and bedrails, diet and nutrition, elimination, pressure care, wounds, oral care, personal hygiene, end of life care and social needs. We also noted cultural and spiritual and any diverse needs were recorded as appropriate. However, we noted the information recorded in the care plans was not always consistent between the various sections. This meant there was the risk of inappropriate care being provided due to conflicting directions for staff to follow.

We saw there were arrangements in place to review and evaluate people's care plans on a monthly basis. However, whilst some relatives had discussed their family member's care plans with staff, people spoken with were not familiar with their plans and could not recall discussions about how they wished to be supported. This is important so people can express their views. For instance, one person told us they would like to bathe more often, but they were unsure how to make staff aware of their wishes.

Staff completed daily records, which provided information about changing needs and any recurring difficulties. Since the last inspection, an increased number of monitoring charts had been implemented in order to monitor specific aspects of people's personal care needs. However, we noted food and fluid charts were completed retrospectively and the records of sensor mat checks were sporadic. This meant there was the potential risk that aspects of people's care were not monitored in a robust way.

People were supported to discuss their end of life wishes as appropriate. The home followed the five principles set out in the "Priorities of care for the dying person." This included the duties and responsibilities of health and care staff to ensure a sensitive and compassionate approach to dying. We noted families were provided with a booklet containing bereavement advice. The staff liaised closely with the district nursing team to ensure people receiving end of life care had access to appropriate equipment and pain relief medicines.

We looked at how the service managed complaints. Whilst some people and their relatives told us they would talk to a member of staff or the registered manager if they had a concern or wished to raise a complaint, other people were unsure of the complaints procedure. We saw information was available to people and their families about how to make a complaint. This information was displayed in the reception and in the information given to people when they moved in.

We looked at the complaints records and noted a central log had been maintained along with investigation reports and outcome records. The records were detailed and the registered manager had carried out analysis to determine any trends. However, we were aware of complaints made to the home, which had not been recorded in the complaints log. The registered manager and area manager told us they maintained separate records of issues raised by relatives. We saw concerns had been investigated and responses had been sent. However, by not dealing with issues under the complaints procedure and recording the concerns on the central log, there was the potential that complaints information was not analysed as whole in order to identify and respond to learning points for future practice.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We looked at how the provider shared information with people to support their rights and help them with decisions and choices. We were advised at the previous inspection, that all information including the complaints procedure could be produced in different formats to meet the communication needs of people living in the home.

Since our last inspection, the entertainment and leisure manager had left the service and a new activities coordinator had been appointed. At the time of our visit, the activities coordinator had not fully commenced work in the home. We observed some activities during the inspection, which included arts and crafts, a church service and a knit and natter group. We also observed a music therapy session, which people noticeably enjoyed. The music therapist was present in the home every Wednesday and provided therapy for both individuals and groups.

There was an activity planner displayed in the home, however, relatives told us the activities did not take always take place as planned. People and relatives told us there had been a decline in the frequency and quality of activities in the home. People said they would particularly welcome more trips out of the home. We also noted there was the potential for people living on Garden suite, which was located on the second floor, to experience social isolation. The registered manager told us she intended to speak with the activities team as soon as the activity coordinator commenced work in order to develop the activities in the home.

Inadequate

Is the service well-led?

Our findings

Before the inspection, we received a significant number of concerns from staff and relatives about the quality of care and the management of the home. During this inspection, people and staff were generally more positive about the management team. For instance, one person told us, "If I had any problems I would go and see [the registered manager], she has always been very kind to me" and a member of staff commented, "[The registered manager] is really trying to build positive relationships up with the staff." In addition, another member of staff said, "[The registered manager] is not given enough credit." However, relatives spoken with continued to express strong opinions about the way the home was managed and many expressed dissatisfaction.

All registered persons have a statutory duty to notify the Care Quality Commission without delay of specific events and incidents which occur in the service. On looking at the incident records, we found we had not been notified about some specific incidents in line with the current regulations. This meant we were not able to consider and monitor the level of risk at the service.

This was a breach of regulation 18 the Care Quality Commission (Registration) Regulations 2009.

Prior to the inspection, we received concerning information about the staff recruitment process. We therefore sought assurances from the registered manager and asked her to submit a list of new staff along with details of a specific pre-employment check. We received the list as requested and both the registered manager and the area manager confirmed the details were accurate and correct. However, on checking the staff files during the inspection, we found a number of pre-employment checks had not been carried out for one member of staff. We were concerned to note the staff member had been omitted from the list submitted by the registered manager and area manager. The registered manager explained the omission was an oversight and said a file had not been set up for the member of staff at the time the list was compiled. However, the staff member was on the rota and we were sent no amendments to the list when the error had been identified. This meant the information provided to us was misleading and inaccurate.

We noted relatives had been given an opportunity to meet with senior managers to express their views on the service in May 2018. We requested and received a copy of the minutes from the area manager. The meeting minutes were detailed and we noted the relatives raised a number of concerns about the operation of the home. We asked the area manager for an action plan, however, we received no response. During the inspection, the area manager explained actions were covered in the meeting minutes. However, whilst the minutes indicate assurances were given to the relatives, there was no clear plan of action with identified timescales to ensure all issues were addressed. Relatives spoken with during our visit felt they had not received feedback from the meeting and one relative said "Nothing has changed."

We saw there had been two residents' meeting since the last inspection and a customer satisfaction survey had been carried out in September / October 2017. We noted 95% of respondents had indicated they felt the home was a safe and secure place to live. We also saw some people had made some positive comments about the approach taken by the staff team, for instance one person had written, "I feel every member of

staff try to do their best." We saw people had also suggested areas for improvement, however, there was no action plan seen to address these issues.

We found there were shortfalls in the records maintained by the service. Whilst there were arrangements in place for staff induction and training. Some staff had no record of a completed induction. This meant it was unclear how staff had been introduced to the home and the role they were expected to carry out. The provider was using four different systems to monitor staff training, we were therefore unable to check records during the inspection. The registered manager offered to send a completed training matrix, however this was not received. Staff completed food and fluid charts in retrospectively after meals, this meant the accuracy of the records was reliant on the staff member's memory. Staff told us they did not always have time to read care plans, therefore they relied on handover records. However, one handover record was found to be blank. Not all complaints were recorded in the central log and whilst concerns had been investigated the themes were not considered as part of the analysis of complaints in order to identify learning points. There were also shortfalls found the records maintained as part of the management of medicines.

The registered manager carried out a series of audits to monitor the quality of the service and completed weekly management reports for the provider. We saw the completed audits during the inspection, however, we found a number of shortfalls during the inspection and identified six breaches in the current regulations. Furthermore, the provider and registered manager had not fully addressed the issues identified at the last inspection and had failed to make the necessary improvements to the management of medicines, the way risks to people' health, safety and welfare were assessed and managed and their understanding and implementation of the Mental Capacity Act. We also found there were significant shortfalls in the staff recruitment process and the provider had failed to notify the commission without delay about some specific incidents which occurred in the home.

The registered manager was supported in her role by an area manager and support manager. They visited the home at least once a week and completed a monthly report of their findings. We were sent a copy of the reports following the inspection. The provider had also carried out a quality assurance assessment and produced an action plan. However, we found a number of shortfalls during the inspection which had not been fully addressed by the provider.

The provider had failed to operate an effective quality assurance system in order to improve the quality and safety of the service. This was a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us she was committed to the improvement of the service, she explained there was now a stronger staff team, people's dependency profiles used to determine staffing levels were fully completed and the catering arrangements were much improved. She added the staff had also worked hard to ensure the care plan documentation was more detailed and there was now information available about people's medical conditions. The registered manager also told us about her priorities in order to improve the service which included engaging the heads of departments, establishing better communication channels and ensuring people, relatives and staff were provided with feedback.

We noted the provider was fulfilling their statutory responsibility to display the rating from the last report in both the home and on their website.