Hilltop Manor Residential Care Home Limited

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Inspection report

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West Yorkshire
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Date of inspection visit:
21 February 2018
12 March 2018
03 April 2018

Date of publication:
18 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 February, 12 March and 3 April 2018. The first day of our inspection was unannounced and the two following days were arranged in advance.

Hilltop Manor Care Home Limited is a 'care home' in the village of Sherburn-in-Elmet. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to provide residential care for up to 35 older people, some of whom may be living with dementia, a physical disability, detained under the Mental Health Act or with mental health needs. At the time of our inspection 34 older people were living at the service.

There was a registered manager in post who was also one of the owners of the service. A registered manager is a person who has registered with the CQC 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 our last inspection in January 2016 we rated the service 'Good' overall. At this inspection the provider required improvement in the safe, effective, responsive and well-led domains. They were therefore rated Requires Improvement overall. This is the first time the service has been rated Requires Improvement.

Staffing levels at night were not safe. The provider did not have a robust system to assess, monitor and ensure staffing levels were safe.

At our last inspection we recommended the provider review the processes to support staff, with a particular focus on supervisions. These concerns had not been addressed and we found staff did not receive the required number of supervisions in line with the provider's policy.

Staff completed training in areas the provider considered mandatory. However specific training, in areas such as dementia care and nutritional support, had not been consistently completed. We found three separate instances where staff required further medication training, due to medicine administration errors, and this had not been completed. The provider did not have a clear policy about how often the care worker's competency to administer medicines should be assessed.

The provider had a programme of quality assurance checks to monitor the safety and quality of the service provided. The checks were limited in their scope and did not highlight the issues we found during our inspection. This increased the potential risk to people and resulted in a breach of governance.

We found breaches of regulation relating to staffing and the governance of the service. You can see the

action we asked the registered provider to take at the back of the full version of this report.

The provider took some actions to address our concerns which included an increase of staff on duty at night, the development of a dependency tool to assess the minimum number of staff required and considered ways to improve their system of governance.

Risk assessments were completed when areas of risk had been identified. However, risk assessments and care plans were not updated when there had been a change in a person's needs or following an accident or incident. Daily records highlighted issues but did not describe the follow-up actions taken by staff. Reviews of people's support were completed but did not evidence they were included in discussions about their care.

Accidents and incidents were recorded, but we found these lacked detail about the management and response to the incident and any lessons learnt.

A fire risk assessment was completed in 2012 but there was record of this been reviewed to ensure it was still up to date. There were also no records of night staff having completed fire drills. Following the first day of our inspection a fire drill was completed.

Medicines were stored and administered appropriately. Protocols to describe when 'as and when needed' medicines should be administered were not always in place and handwritten entries on people's medication administration records were not consistently countersigned. We recommended the provider implements best practice guidance in relation to medication administration.

Staff continued to be recruited in a safe manner. Care was provided by a consistent staff team. Staff understood signs of abuse and knew how to report their concerns. This ensured people were protected from abuse.

At the last inspection we recommended the provider consider best practice in relation to a 'dementia friendly' environment and noted parts of the service required redecoration. At this inspection we found heavily patterned carpets had not been replaced, there was limited signage to enable people to move around the building unaided and the décor required updating.

People who used the service and their relatives told us they enjoyed the food. People were regularly weighed and staff sought the support and advice of professionals when there were concerns about weight loss.

People were supported to have maximum choice and control of their lives and staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us staff were kind and respected their privacy. Staff had a good knowledge of people's likes, dislikes and needs. Staff had established a rapport with people's relatives. People were provided with dignified end of life care.

Various activities were available, which included crafts, playing quizzes and watching performances. Activities coordinators were employed at the service and had worked with healthcare professionals to develop stimulating and person-centred activities for people.

People who used the service and their relatives told us they felt able to report any concerns to the staff or

management team. The overview of complaints required further development to ensure this demonstrated a clear and transparent approach to investigating complaints.

Resident and relative meetings were held to hear people's views on the service and ways in which it could improve.

The management team received positive feedback from staff, the people who used the service and their relatives.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Night time staffing levels were not safe. The provider has increased staffing levels since our inspection.

Medicines were safely administered however record keeping was not in line with current best practice.

Risk assessments were not routinely updated when there had been a change in a person's needs.

Accident and incident reports contained limited information and records did not demonstrate lessons were learnt following incidents.

Staff continued to be recruited in a safe manner.

Staff understood their responsibility to safeguard people who used the service from abuse or avoidable harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular supervisions in line with the provider's policy.

The environment did not promote people's independence, particularly for people living with a dementia.

People who used the service had access to healthcare professionals and staff had developed close links with services.

The staff understood and followed the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

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

Staff had developed positive relationships with the people they supported.

People received dignified care and staff ensured people's privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not robustly completed when a person's needs had changed.

Information contained in reviews was basic and did not evidence people's involvement in discussions about their support.

People enjoyed the activities on offer and the service was developing meaningful and person centred activity.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not have systems in place to robustly assess the number of staff required to safely meet people's needs.

The provider did not have effective systems in place to monitor the safety and quality of the service. The systems in place had not highlighted the issues we found during our inspection.

We received positive feedback about the leadership from people who used the service, their relatives and staff.

Hilltop Manor Care Home Limited

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.

We inspected the service on 21 February, 12 March and 3 April 2018. This inspection was unannounced. The first day of our inspection was completed by two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service. The expert by experience supported this inspection by speaking with people who used the service and their relatives to help us understand their experiences and views on the service. The second day of our inspection was completed by two inspectors and a pharmacy inspector. Two inspectors were present for the third day.

Before our inspection we reviewed information we held about the service, which included information shared with the CQC and statutory notifications sent to us since our last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service which may affect the people they support. We also considered the Provider Information Return. This is information providers are required to send us at least once annually and gives key information about the service, what the service does well and any planned improvements. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer group who share the views and experiences of people using health and social care services in England. We used this information to plan our inspection.

During the inspection we spoke with six people who used the service and four people visiting their friends or relatives. We spoke with 11 members of staff which included the registered manager, deputy manager, senior care workers, care workers, activities coordinator and the cook. We also received feedback from three visiting professionals.

We had a tour of the service including communal areas and, with permission, looked in people's bedrooms. We observed interactions between staff and people who used the service including at lunchtime and during activities. We also observed a staff handover and staff supporting people to take their medicines.

We reviewed a range of records during our inspection. This included six staff files, which contained information about supervisions, appraisals and training. We looked at the documentation for five people who used the service, which included care plans, risk assessments and daily records. We also checked the medication administration records for five people. We were provided with a range of documentation in relation to the running of the service and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

There were insufficient care staff on duty at night, particularly in the event of an emergency. In reaching this decision we reviewed the needs and levels of dependency of the people who used the service alongside the layout of the building and any additional responsibilities night staff had.

At the time of our inspection there were two night staff on duty to meet the needs of 34 people some of whom had varying levels of confusion, could be resistive to interventions, and were awake and mobile throughout the night. On the first day of our inspection there were 12 people who required support from two staff with personal care. The service also provided end of life care for people who required additional checks and assistance to ensure they were comfortable. Night staff were also routinely expected to undertake non-care duties, such as cleaning, laundry and kitchen duties.

The provider did not complete a dependency level assessment of the people who used the service. This assessment tool determines how many staff should be on duty over a 24-hour period.

Staff told us they completed three routine checks during the night; at 10pm, 1am and 4am. During these times there would be no staff to monitor and support people who were awake in communal areas or negotiating the stairs. The notes of night staff meetings and the staff handover book highlighted people who were frequently awake during the night or required additional support with their personal care needs. Call bells could not be clearly heard in all rooms of the service, which could lead to delays in staff responding to urgent situations.

An example of our concerns related to a person who was frequently up throughout the night. Their falls risk assessment noted staff needed to have knowledge of their whereabouts. There were 23 recorded incidents involving this person, since 3 January 2018, with some being at night time. Another person's care records described how they sometimes needed support from three members of staff with their personal care, which the provider would be unable to provide at night time.
Some of the night staff told us about the difficulties of coping at night and their worries that people's needs were not always met. One care worker told us, "I don't feel the residents are getting the care they deserve."

Due to the majority of people's complex needs, they were unable to tell us whether staff provided appropriate support at night time.

The failure to develop a systematic approach to determine the number of staff required overnight and to ensure sufficient numbers of staff were deployed to meet people's needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our serious concerns about night time staffing levels with the provider. After our final site visit they informed us staffing levels had been reviewed and there were now three night staff on duty. The provider had started using a dependency tool, which showed the service was now staffed in accordance with the needs of people using the service. Action had been taken to resolve the issue with the call bells.

Relatives told us there were sufficient staff on duty when they visited during the day. Comments included, "Family members have said that they couldn't believe how many staff worked here" and, "There are always staff about." We observed lots of staff moving around the service during the day.

There had been a significant number of accidents throughout the 24 hour period and some serious incidents had occurred. For example, there were 43 recorded accidents in January 2018. These included entrapment at the side of the bed and near misses on the stairs at night. The accident and incident reports lacked detail about the management of and response to accidents, any 'near misses' and what lessons staff could learn from these.

When an accident or incident had occurred staff did not routinely update the person's care plan or risk assessments. For example, a person had been found trapped at the side of their bed, against the wall. Staff had failed to document the entrapment within the person's care plans or risk assessments. This meant people's documentation was not up-to-date which created the risk that staff may not have a full understanding of the support required.

A fire risk assessment was last completed in 2012. Although the provider advised this had been informally reviewed the paperwork had not been updated and they agreed to address this. On our first day of inspection we identified night staff had not taken part in regular fire drills. This meant we could not be confident night staff had the necessary skills and knowledge to respond in the event of a fire. On the second day of our visit the provider had completed a fire drill with night staff which included simulation of fire evacuation techniques.

Checks of sensors, used to automatically alert staff if a person needed assistance, were not completed to ensure they were in safe working order. We discussed this with the provider who agreed to complete these. Other records which related to the checks of the building and equipment used were in place, which helped to ensure the safety of the people who lived at the service.

Medicines were stored securely in a locked room. Records demonstrated medicines were stored at the correct temperature. The provider had a process for ordering and checking there was sufficient stock and medicines no longer required were returned to the dispensing pharmacy.

Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored in a suitable cupboard. When a controlled drug was administered, the records showed the signature of the person administering the medicine and a witness signature. Staff told us stock checks were conducted weekly. However, we saw two controlled drug records that did not show a weekly stock check.

Staff administered medicines with care and patience and tailored the administration to the needs of the individual. They followed a safe method for giving and accurately recording medicines administered. Handwritten additions were made to medication administration records, but had not been signed by two people to ensure they had copied the instructions correctly. The provider's medicines policy noted this was required. The provider did not have topical administration records to show creams and ointments were being applied as prescribed.

Individual written guidance for medicines prescribed to be taken 'when needed' or 'as directed' were not always available. This guidance should clearly explain in what circumstances the medicines should be administered and how often it is required to ensure staff administer these in a safe and consistent way.

The deputy and registered manager completed monthly medicine audits. Although audits identified some

areas for improvement and actions to take, they had not consistently identified the issues we highlighted during our inspection.

We recommend the provider implements best practice guidance relating to the management and recording of the support provided with people's medicines.

People's needs were assessed and risk assessments completed in areas such as nutritional needs and falls risk. To risk assess and respond to risk around people's skin, staff used a recognised tool called a 'Waterlow'. Although the Waterlow was completed and reviewed the scoring to indicate the level of risk was not. This is an important step as the level of risk identifies actions required to respond to and reduce risk.

When people had pressure sores, management plans were not introduced to clearly explain the support required. 'Repositioning charts' were inconsistently completed. Repositioning charts are used to document how often people with fragile skin are supported to change their position to relieve pressure and avoid the risk of further skin breakdown. A visiting professional told us staff did manage people's skin well and would seek advice if they noted a change or deterioration in a person's skin. Staff were also able to describe to us what actions they had taken to promote people's skin integrity. We therefore concluded this was a recording issue. We discussed this with the provider who agreed to relay the importance of accurate recording to staff.

People who used the service told us they felt safe. One person said, "Yes definitely I feel safe. The staff just do their job." A relative told us their family member had fallen on several occasions and noted, "Staff are there to assess [the person] straight away. They will then assess whether they need to go to hospital or arrange for a doctor."

There was a consistent team of staff. The service did not use agency staff. People continued to be recruited in a safe manner to ensure new staff were suitable to work with people who may be vulnerable.

The provider had a safeguarding policy in place. Staff understood the signs and symptoms which may indicate people were experiencing abuse, and knew what action to take to ensure people were safe. Safeguarding concerns were identified and appropriately reported to the local authority safeguarding team.

Rooms which contained hazardous materials or chemicals were locked as required. Personal Protective Equipment (PPE) such as gloves and aprons were available to help prevent and control the spread of infection.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we recommended the provider review the systems in place to support staff, with a particular focus on the recording of supervisions. Supervision is a process, usually by way of a meeting, for a provider to monitor and support the learning, development and well-being of their staff. The provider's policy stated staff should have four supervisions a year, which included an annual appraisal of their performance. Of the three staff files we looked at, all had an appraisal of their performance within the last twelve months. However, two members of staff had not received supervision for six months, whilst another person last received supervision in April 2017. The provider agreed supervision records should have been completed and told us they would monitor and ensure their completion in future. In addition, we noted the supervision template required further development to ensure the information recorded from supervisions was sufficiently detailed and reflective of the discussions had.

A number of people who used the service had complex nutritional needs, however, only eleven members of staff had completed training on how to promote good nutrition. The provider advised, on our last day of inspection, they were in the process of sourcing additional training. Approximately half of the staff team had completed training in relation to dementia care, most of which was not completed in the last twelve months. This training is important for a service which delivers specialist support to people living with dementia. The provider was aware this training required updating and a senior care worker had recently attended a training course to enable them to deliver dementia training to the staff team. The provider also had close links with the community mental health team and the occupational therapist who had started to deliver training in the area of positive behaviour support. Positive behaviour support is a person-centred approach to supporting people who have behaviours which may be challenging.

Staff completed medicines training and refresher training annually. However, competency assessments had not been completed with all staff to ensure they had sufficient knowledge and skills to administer medicines safely. The provider was not clear about the frequency of the competency assessments. We saw three instances where care workers had been identified as needing further training following a medicine error, but this had not taken place.

A failure to provide appropriate support, training, supervision and appraisal is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our last inspection we recommended the provider consider best practice in relation to the 'dementia friendly' design of the service, this included replacing heavily patterned carpets. For people living with dementia heavily patterned carpets may cause confusion as, for example, the patterns could be seen as objects. At this inspection the environment had not been updated; the décor of the service remained tired and patterned carpets had not been replaced.

The provider showed us an action plan for the redecoration and maintenance of the service which included the replacement of carpets. We noted some improvements had been made such as the replacement of the kitchen floor and updated wet room. Despite these efforts, there had been a significant delay with

implementing recommendations from our previous inspection.

Some attempts had been made to consider the environment for people living with dementia, for example handrails were of a contrasting colour to the walls and toilet seats were a brighter colour. There were some physical limitations with the environment, for example a dark corridor with no natural light. The lighting had been replaced, but the corridor remained dark with no clear signage. This could pose a risk to people living at the service. Staff understood the limitations of the building and escorted people however the environment did not promote people's independence.

People who used the service were regularly weighed. The provider was, however, unable to evidence the weighing scales had been calibrated to ensure they gave an accurate reading. They agreed to address this.

When staff had concerns about weight loss they liaised with the GP and completed a nutritional risk assessment to identify the level of risk and detail any actions needed. When there was a change in a person's needs, such as having lost weight, the risk assessment tool was not consistently updated to ensure it reflected their current needs. Staff did not consistently record people's nutritional and fluid intake on their charts. 'Food and fluid charts' are used when there is a concern a person is losing weight and their intake needs monitoring. Charts being only partly completed means the chart doesn't provide an accurate picture. We discussed with a healthcare professional concerns about people's weight loss within the service. Their view was the staff managed people's nutrition in a satisfactory manner and felt there was a lack of support for the service in this area.

We received positive feedback about the food served. A relative noted, "It always looks great. [Relative's name] will say, I do love the food." A person who used the service told us, "It is good, never had a bad meal yet."

We observed the lunchtime experience. The food was hot and smelt appetising. There were plenty of staff available to support people with their meal. We observed some meals were served on a small side plate which meant the person had a much smaller portion. The provider agreed to address this. Tables were not inviting with no table cloths, condiments or menus. We discussed this with the provider and actions were taken before the second day of our inspection; side plates had been removed, some tables replaced and condiments were available.

People who used the service told they had access to healthcare professionals. The staff team liaised with external agencies which included district nursing teams, speech and language specialists and emergency care practitioners. Visiting professionals were very positive about the support provided to people living at the service and noted staff sought their support and advice. A healthcare professional said the staff provided people with holistic care.

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 MCA 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive people of their liberty were

being met. We found the provider and staff team had a good understanding of mental capacity and these principles were promoted through the delivery of care. Applications to deprive people of their liberty had been submitted appropriately. This ensured people's rights were protected.

Good

Is the service caring?

Our findings

Without exception, we received positive feedback from people who used the service and their relatives about the staff. People told us, "They are lovely lasses. Nothing is too much trouble", "I think they are all lovely. Can't fault them" and "They do care about people. They are very good actually." Another person said they could talk with staff about anything. A relative explained, "What I like about my [relative] being here is the attitude of the staff. They make them feel cared for." A visiting professional described the staff as, "Second to none."

Staff were patient and kind in their interactions with people. They spoke with people at eye level and placed a reassuring hand on top of theirs to let them know they were there. Staff laughed, joked and danced with people. They had a good rapport with the people they cared for and asked how people's relatives were and talked about shared interests.

We asked people who used the service and their relatives whether staff treated them with dignity and respect. A person who used the service noted, "They treat you as nice people." A relative told us, "Yes definitely. I can hear things in the background and see staff. I've never seen them do anything disrespectful to anyone." Staff understood the importance of promoting people's dignity. They knocked on people's bedroom doors before entering, closed doors when support was being provided and addressed people in the manner of their choosing.

Staff had considered ways to reduce isolation for people who required nursing in bed and were not able to spend time in the communal areas. The provider noted a person who really liked listening to music, so they ensured music was playing and spent time reading to them. Staff had hung a very lightweight curtain over their door so the person could still hear and see what was happening, but had some privacy. Staff closed their door when personal care support was provided.

Relatives confirmed staff maintained regular communication with them. Visitors to the service said they always felt welcomed. One person noted, "I enjoy coming here and the staff are always kind and attentive." Staff asked visitors how they were and appeared to have genuine concern for their well-being. A relative of a person who used the service visited their relative and then spent time in a quiet area having a rest, knowing they were close to their loved one. Staff supported this, understanding the importance of helping people to maintain important relationships. We also observed staff talking with a recently bereaved relative. Their interaction was gentle and showed genuine concern and empathy.

Staff encouraged people to be independent. For example, we heard a member of staff trying to encourage somebody to take their shoes off. When the person questioned whether they could, the staff member gave lots of reassurance explaining they were able to and the two could be heard laughing together.

The provider understood the role of advocacy services in supporting people to make important decisions. Where necessary, people had been supported by an advocate to ensure their wishes and views were heard.

Requires Improvement

Is the service responsive?

Our findings

People's presentation, the support provided and areas of concern were documented within their daily records and discussed at staff handover. We found entries within people's daily records where staff had noted a change in their needs or presentation, for example an area of redness on their skin, and follow-up actions were not documented. Staff explained people's current needs and the actions taken in response to these concerns, but this had not always been documented. This was highlighted to the provider during our visit and they agreed to address this with staff.

Each person who used the service had an individual care plan for different elements of their support, which included personal care, nutrition and skin integrity. Care plans contained some person-centred information which included information about people's history, likes and dislikes. When changes in a person's needs were noted there was a handwritten update within their care plans which did not provide a full explanation of the changes or a description of how to meet their needs.

Reviews of people's care plans were completed and recorded on a review document. These often contained minimal information or simply stated, 'No changes.' Relatives told us they were kept informed of any changes but records did not evidence people, or their relatives, were included within these reviews. We discussed this with the provider who agreed to review the process to make sure they were person-centred in their approach.

Assessments were completed before people moved into the service to make sure their needs could be safely met. The staff also worked closely with the GP to devise health plans to support people to remain at the service and avoid unnecessary hospital admissions.

The staff used sensors, such as pressure mats next to people's beds, to ensure people's movement was not restricted, but to alert staff that assistance may be required.

No formal complaints had been raised within the last twelve months. Informal complaints had been made and responded to. However, there was no clear overview of when complaints were received, how they were investigated and any lessons learnt as a result of this. This would evidence a clear, transparent approach to investigating and addressing any concerns We discussed this with the provider. People who used the service and their relatives told us they would feel confident to raise any issues with the staff or provider.

There were two members of staff who took responsibility for arranging activities. One of the activities coordinators had devised a questionnaire for people who were new to the service. It asked questions about their life history, hobbies and interests. Activities could then be tailored to people's own interests. The activities coordinator had spent time with a professional from the community mental health team to further develop meaningful activity and stimulation for people, with a particular focus on people living with dementia

The activities coordinator showed us a timetable of activities, but they noted activities can vary according to

what the people who used the service wanted to do.

Staff engaged people in activities on a one-to-one basis such as dominos, completing a jigsaw and listening and dancing to music throughout our inspection. There were photographs of recent events that had taken place, which included a cheese and wine evening and people making valentines cards. A person we spoke with also told us about a recent trip to Bridlington and people had also visited garden centres, 'Tropical World' and a pantomime was performed at the service. The provider told us some people enjoyed walking into town and staff accompanied them. The records we saw confirmed this. The activities team had previously arranged parties to celebrate special times of the year such as Easter and Christmas.

Staff provided people with end of life care and a visiting professional told us this was of a good standard. For a person receiving end of life care at the time of our inspection, staff continually updated the provider about the person's presentation. An end of life care plan was in place which was detailed and person-centred and noted the person's and their family's wishes.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager and they were supported by a deputy manager, administrator and senior members of the care team. Throughout the inspection the management team were open and honest with the inspectors and were responsive in addressing the concerns we had.

At our last inspection we recommended the provider review the systems in place to support staff, with a particular focus on supervisions records, and to consider best practice in relation to a 'dementia friendly' environment. At this inspection the provider had not adequately updated the environment to promote people's independence. They had not developed effective systems to ensure staff received regular supervisions.

Staff who required additional training as a result of a medicine administration error, had not completed this. Competency assessments had not been completed for all staff who administered medicines to ensure they had the necessary skills and knowledge.

Staffing levels had not been reviewed by the provider and, although staffing levels during the day were safe, staffing levels at night were unsafe. Although this has been addressed by the provider since our inspection, this was reactive and not proactive management.

We looked at the procedures in place for quality assurance and governance. These enable registered managers and providers to monitor the quality and safety of the service and to drive improvement.

The provider had an accident reporting policy in place and completed an audit of accidents and incidents. The audits were not effective in ensuring all actions had been taken in response to accidents, including the person's documentation been updated. The provider made changes to the recording and monitoring of accidents and incidents during our inspection.

The provider also completed or delegated a range of audits which included checks of the premises, environmental cleanliness and medicines. In addition to this, a monthly manager audit was completed, which covered areas of the service such as staffing, housekeeping and records in relation to the running of the service and the people who lived there.

During our inspection we found a range of documentation that had not been completed or updated which the system of audits had not highlighted. This included risk assessments, charts detailing the support a person was provided with and incomplete management plans for areas of risk such as the support required to manage pressure sores. Medicine audits were completed and although they noted some areas for improvement, these had not highlighted the issues we found with medicine documentation.

The audits had not identified issues relating to the safety of the premises, which included not documenting updates to the fire risk assessment, no record of the night staff having completed fire drills and checks of the equipment including sensors and calibration of weighing scales.

At our last inspection we recommended the provider consider best practice in relation to a 'dementia friendly' environment and noted areas of the service which required redecoration. Some maintenance had been completed, and the provider had an action plan moving forward, however there had been a significant delay in making the necessary changes to the environment.

There was a breach of regulation in relation to staffing. These concerns showed us systems and processes were not established and operated effectively to ensure the quality and safety of the service. This meant people who used the service were at risk of harm and was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and their relatives provided positive feedback about the management team. One person stated, "They [the registered manager] are brilliant." A relative told us, "The management team are really successful. Most of the staff have been here a long time and that means something." Another person noted, "You want them [your relative] to be well cared for and clean and they are. There is nothing for the service to improve on."

The staffing team provided positive feedback about the registered manager. A member of staff told us the service was well-run and noted, "[The registered manager] has a lot of input into the care of the residents and knows them inside out." The registered manager was visible, staff regularly approached them for information or guidance and they knew the needs of the people who used the service.

The registered manager held different types of staff meetings, which included senior care workers, night staff and full team meetings. Records showed staff were able to express their views and the registered manager communicated important information with them.

The registered manager arranged 'residents and relatives' meeting to seek people's views on the running of the service and to discuss how improvements could be made. At the most recent meeting, people said they wanted to go on more outings, have a fish and chip meal and requested items be added to the menu including different flavours of ice-cream. The registered manager developed an action plan, which showed how they had responded to the suggestions. This included hiring a minibus for people to go out, food items added to the menu and people who used the service had a fish and chip meal. This demonstrated the registered manager acted on the views of people who used the service.

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 Systems and processes had not been established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and to improve the quality and safety of the services provided. Regulation 17(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to develop a systematic approach to determine the number of staff required to meet the needs of the people who used the service. Staff did not receive appropriate training or supervision to enable them to carry out the duties they were employed to perform. Regulation 18 (1)(2)(a).