Mrs F C Robson

Overstone Retirement Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Overstone Retirement Home is a residential care home based in Hexham, Northumberland which provides accommodation and personal care to up to 15 older people. People are accommodated over two floors and some people living at the home were living with dementia. Our first rated inspection of this service was carried out in March 2015 at which time we found the provider to be in breach of Regulations 13 (Management of medicines) and 20 (Records) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In response to this the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches.

This inspection took place on the 7, 8 and 11 July 2016 and was unannounced. The inspection was carried out by one inspector. At this inspection we found some improvements had been made to records and recording, but there were continuing shortfalls in the management of medicines. In addition, the provider was found to be in breach of other regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's registration does not require a registered manager to be in post to manage the carrying on of the regulated activity, because the provider is an individual in day to day charge of the service. The registered provider is the 'registered person' under their registration with the Care Quality Commission. 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.

People told us they felt safe living at Overstone Retirement Home. They described a comfortable service where they were cared for by kind, patient and caring staff.
We found medicines management was not robust and we could not be sure that people received the medicines they needed at the right time. There were gaps in the recording of the administration of medicines and care planning around medicines had not been fully undertaken. People who were prescribed medicines to be taken "as and when required" did not have specific care plans in place to help staff identify when people may need these, for example, when they showed signs of pain. Controlled drugs were not always booked into the home correctly.

Staff had undertaken training in safeguarding but they did not always put this training into practice. Staff shared with us some safeguarding concerns and confirmed that they had not always reported these to the provider. In addition, we found some issues had been shared with the provider but she had not reported these matters of concern to the local authority safeguarding adults team. This showed that staff and the provider were not clear on their personal responsibilities to safeguard people from abuse and improper treatment.

Environmental risks within the service had not always been identified and mitigated against. For example, there were no window restrictors on the upper floor windows. Water temperature checks to prevent the development of legionella within the water supplies of the home had not been carried out in recent months.

Emergency planning had not been undertaken although fire evacuation procedures were in place.

Accidents and incidents were managed well and people received the attention and support they needed.

Staffing levels were consistently maintained and recruitment procedures were thorough. Staff training was carried out in key areas, such as equality and diversity and moving and handling and in areas specific to the needs of the people who they supported, such as nutrition awareness. Staff supervisions were carried out but appraisals had not been completed.

People said that staff met their needs and relatives reflected they were happy with the care their family members received. Healthcare professionals spoke highly of the service and said that any requests they received for support or input into people's care, were both proportionate and appropriate. People were supported to maintain their general health and wellbeing and attend appointments, for example, with their dentist and opticians. Where people were ill records evidenced that GP's were called.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. Applications to deprive people of their liberty lawfully had not always been made to prevent them from coming to any harm where they lacked capacity. The provider and senior care worker told us they had assessed people's capacity when their care commenced and on an on-going basis, when necessary. They advised that no best interest decision making had taken place in the service that they could recall, but that they included people's families in any larger care based decisions and they would continue to do that in the future, documenting decision making where necessary.

People were supported to eat and drink in sufficient quantities to remain healthy. Monitoring tools were available to ensure that where there were changes in people's health and wellbeing this was identified and actions were taken to prevent any deterioration in people's conditions.

Staff and people enjoyed good relationships with each other. We observed staff treated people with respect and people told us that their dignity was maintained at all times. People were encouraged to be as independent as possible and they told us they made their own choices. Several people accessed the community on their own, or with friends and family. People pursued activities of their choosing. Due to the nature of people's needs there were limited activities within the home but a large selection of films, games and books. People told us they enjoyed a film night.

Care records were person-centred and provided staff with information about people's dependencies, needs and the risks they faced in their daily lives. Care records were regularly reviewed. People and their relatives told us they had not had any reason to complain about the service and records reflected no complaints had been made.

The provider was not actively involved in the running of the service and did not effectively oversee the management aspects of the service, leaving this responsibility with a senior care worker. The provider confirmed she was not aware of relevant requirements and best practice guidance, for example, about health and safety in care homes. Auditing was limited and where shortfalls were found, for example in medicines, these were not always addressed.

The provider had not notified the Commission about other incidents that had occurred since our last inspection and they had not displayed the rating from their previous comprehensive inspection within the home, in line with legal requirements. The provider was not aware that the shortfalls we identified at this inspection existed and said staff had not shared some of these with her. She informed us that she did not

carry out any audits at provider level, to measure the standards of the service delivered and to identify any shortfalls that needed to be addressed..

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulations 12, 13, 17 and 20A. In addition, we identified one breach of the Care Quality Commission (Registration) Requirements 2009, namely Regulation 18. Full information about CQC's regulatory response to any concerns found during this inspection will be added to the report after any representations and appeals have been concluded.

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.

Previously identified shortfalls in medicine management remained.

Not all environmental risks had been assessed and mitigated against, and this posed a risk to people's health and wellbeing.

Staff did not always report matters of a safeguarding nature and when they did, the provider did not refer these on to the local authority safeguarding team.

Staffing levels within the home were set at a level which met people's needs. Recruitment procedures were appropriate.

Is the service effective?

Requires Improvement

The service was not always effective.

Applications had not been made to the local authority to assess whether certain people needed Deprivation of Liberty Safeguards to be put in place, in line with the requirements of the Mental Capacity Act 2005 (MCA).

People spoke highly of the staff team and said their needs were met. Staff were knowledgeable about the people they cared for.

People received appropriate care and support to meet their nutritional needs. They spoke highly of the food they were offered.

Staff had received training in key areas and received supervision. Appraisals were not being carried out and improvements were needed to the staff induction programme.

Is the service caring?

Good

The service was caring.

People, their relatives and healthcare professionals spoke very highly of the relationships they enjoyed with staff.

Staff supported people in a polite, pleasant and respectful manner. Their privacy, dignity and independence was promoted.

People's diverse needs were met.

People's involvement in the running of the service was limited.

Is the service responsive?

Good

The service was responsive.

People and healthcare professionals linked to the home spoke highly of the responsiveness of the service.

Care records were person-centred, current and detailed.

Monitoring tools were used to ensure people got the help they needed when they needed it.

People made their own choices and pursued their own activities.

There was a complaints process in place.

Is the service well-led?

Inadequate

The service was not well led.

The provider had limited involvement in managing the service.

There was a lack of knowledge and understanding about legal requirements and elements of the provider's registration with the Commission were not correct.

Limited auditing was carried out and any shortfalls that were identified were not always addressed.

Overstone Retirement Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide an up to date rating for the service under the Care Act 2014. At our inspection of this service in March 2015 we found the provider to be in breach of Regulations 13 (Management of medicines) and 20 (Records) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This inspection was also carried out to check whether improvements had been made.

This inspection took place on 7, 8 and 11 July 2016 and was unannounced. The inspection was carried out by one inspector.

Prior to this inspection the provider completed a Provider Information Return (PIR). A PIR asks the provider for information about the service and any improvements that they plan to make. We reviewed the information on this PIR and also information that we held about the service including any statutory notifications that the provider had sent us and any safeguarding information received within the last 12 months. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of incidents that have occurred within the service. In addition, we contacted Northumberland Safeguarding Adult's team, Northumberland Local Authority Contracts and Commissioning team and Healthwatch. We used the information provided to inform the planning of our inspection.

As part of our inspection we spoke with eight people, three people's relatives, four members of the care staff team, the cook and the registered provider. We also spoke with two healthcare professionals who visited the home during our inspection. We reviewed a range of records related to people's care and the management of the service. These included looking at five people's care records, five staff files, and other records related to quality assurance and the operation of the service such maintenance records and audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2015 we identified shortfalls related to the management of medicines and issued the provider with a compliance action. At this inspection we found the shortfalls previously identified in respect of this legal requirement remained.

We reviewed 13 people's Medicines Administration Records (MARs). We were not always able to evidence if people had received the medicines they needed, as there were gaps in the recording of the administration of medicines. For example, we saw in one case there was no coding or signature entered next to a dose of antibiotic medicine that the person should have been given. Therefore, we could not establish if the medicine had been taken, if the administering person had forgotten to sign the sheet, if the medicine had been offered and refused, or if the person had not been offered it at all. This was the case with a number of MARs. In total, five out of 13 records had a number of missing signatures of the administering staff member. In some cases people were prescribed medicine to be taken three times a day but records showed that they had only taken this medicine, twice a day.

Where people were prescribed topical medicines, such as creams and ointments applied to the skin, the provider and senior care worker advised that the care worker with medicines responsibility may delegate the responsibility for the application of this topical medicine to another care worker on duty. We found gaps in the recording around the administration of these medicines and the provider and senior care worker confirmed that topical medicine administration records were not used to evidence that topical medicines had been applied. We could therefore not be sure that people had received or had their creams and lotions applied appropriately. Where people had been prescribed topical medicines MARs had body maps attached, but these were rarely marked to show where on the person's body the medicine needed to be applied.

Some people had been prescribed medicines to be taken 'as and when required', such as, Paracetamol for pain relief. There were no care plans in place regarding the administration of these types of medicines. This meant there was a risk that staff would not know when people needed to be offered their 'as and when required' medicines, as there was no person-specific guidance available to inform them about when they may be required. For example, including information about the signs people may display when experiencing pain or discomfort.

We reviewed how controlled drugs were managed and stored within the service. Controlled drugs are medicines that are subject to legal controls to prevent them from being misused, obtained illegally and causing harm. The storage of controlled drugs was appropriate but the system in place for booking controlled drugs into the home was not robust. We found two packets of controlled drugs were present in the controlled drugs cabinet which had not been booked in and entered into the controlled drugs register, in line with legal requirements. These drugs had been present in the home and unaccounted for, for over two weeks at the time of our visit. This meant there was a risk they could go missing or be misplaced without this being detected.

Some people self-medicated and stored their medicines securely within their bedrooms. Although this had been risk assessed, records showed that these medicines were not booked into the home and recorded on people's MARs at the time they were delivered. This meant there was no record of how much of each medicine was received, in order to establish how much had been taken and how much should be left.

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

Staff had undertaken training in safeguarding and were knowledgeable about the procedures they should follow, if matters of a safeguarding nature arose. However, they did not always apply this training and knowledge in practice. Staff informed us about safeguarding incidents that had occurred within the home which they had been aware of, but not escalated to the provider or Northumberland Safeguarding Adults team for investigation. Staff also told us they had reported some concerns to the provider and the provider confirmed they had dealt with these matters internally and had not notified the local authority safeguarding team in line with protocols. We checked the safeguarding log retained within the home and saw there were no entries. We discussed safeguarding with the provider and who reflected that they did not have a thorough understanding of their responsibilities in this area. This meant there was a risk that people may not be protected from harm and abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safeguarding service users from abuse and improper treatment.

Not all environmental risks within the premises had been assessed. We saw that the upper floor windows did not have tamper proof window restrictors in place in line with Health and Safety Executive guidance. The provider and senior care worker told us that four people in the home had dementia and three of these people lived in upper floor bedrooms. We considered that people living with dementia may be at a risk of falling from height as these windows could be opened fully. The provider acknowledged our concerns and took action on the first day of our inspection to address this by ordering the appropriate restrictors. Following our inspection the provider has confirmed that window restrictors have been fitted to a number of the upper floor windows to reduce this risk and as soon as more stocks are received the remaining windows will be secured.

The safety and suitability of the electrical installation had been tested and where shortfalls had been identified repairs had been carried out. Gas safety checks, fire safety checks and a risk assessment to prevent the development of Legionella bacteria within the water supplies, had been undertaken. The lift and equipment used during the delivery of care were regularly serviced to ensure they remained safe for use. However, we saw that checks on the water temperatures within the building had lapsed and had not been carried out since February 2016. This meant there was a possibility that water temperatures may not be maintained at safe levels as a control measure against the development of legionella bacteria.

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

Although fire evacuation procedures were in place, no individual assessments of the support people would need to evacuate the home in an emergency had been considered or drafted. This meant there were no instructions for staff to follow. There was no information for staff to refer to, for example, if there was a loss of power in the building or if members of the staff team were struck down with an illness. The senior care worker told us this was something they planned to review.

Accidents and incidents that occurred within the home were recorded individually and monitored for trends and patterns. Details of the date, time and people involved and circumstances of each accident or incident were maintained. Where people had fallen more regularly input into their care had been sought from, for example, occupational therapists to see if there was equipment the person could use that would support them. A monthly analysis of accidents and incidents was retained on an individual basis in people's care records and included a graph which plotted a visual pattern for review.

Staffing levels within the home were consistently maintained. On each of the days that we visited a minimum of three care staff were on duty and this was an appropriate staffing level to meet people's needs. People told us that if they rang their call bell for assistance staff came promptly. The provider told us that over the last few months the senior care worker had been required to spend more time delivering care rather than completing office based tasks, in order to cover staff sickness and holiday leave, but this was a temporary arrangement. Following our inspection the provider informed us the senior carer had returned to her main role.

Staff files demonstrated that the provider's recruitment and vetting procedures for new staff were appropriate and protected the safety of people who lived at the home. Application forms were completed, including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children. This demonstrated the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and of suitable character to do their jobs.

People told us they felt safe living at Overstone Retirement Home. Their comments included, "I feel safe here; I just feel that I am at home here" and "The staff are lovely with us and very patient". People's relatives and visiting healthcare professionals told us they had not witnessed any incidents or issues with staff practice when they visited that they would consider to be inappropriate or unsafe. One visiting healthcare professional said, "Nothing worries me when I come here. It is nice".

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered provider and senior care worker told us they had not needed to instigate any best interest decisions to date, in line with the principals of the MCA 2005. People's care records showed some assessments of people's capacity levels had been carried out but this was an overall assessment of capacity and not a capacity assessment that was decision specific.

The registered provider explained to us how she involved people's families in minor care based decisions and would continue with this approach, including relevant healthcare professionals, where necessary, if any best interest decisions needed to be made in the future. 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were in place, where people had consented to these. Where they were unable to consent a communal decision, instigated by a clinician, had been made.
However, applications to lawfully deprive people of their liberty (DoLS) had not always been made to the local authority safeguarding team in accordance the legal requirements of the MCA. In one case, a person had been granted a 12 month DoLS but this had expired in February 2016 and no further application to extend this had been made. The provider and senior care worker informed us that three further people who lived at the home potentially required assessment for a DoLS to be put in place, but they confirmed that this had not yet been done.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safeguarding people who use services from abuse and improper treatment.

Feedback about the effectiveness of the service was positive. People spoke highly about the staff team and said their care needs were always met. One person told us, "I am very well looked after and the staff are excellent" and another said, "If I needed anything the carers would get it for me". A third person commented, "I do get help with everything I need help with - day or night there is someone who answers the bell (bell used to call for staff assistance)". Feedback received via questionnaires issued by the provider was positive and complimented staff on their caring, patient and helpful manner.

Relatives told us they were pleased with the care their family members received and spoke highly of the service and staff team. One relative told us, "We are very, very happy. I don't worry about (person's name) being here". Visiting healthcare professionals praised the staff and service and said they were satisfied that

staff knew people's individual needs well and any referrals made to them were appropriate. One healthcare professional commented, "Staff seem to be alert to people's needs. The requests they made are justified. They seem to know people inside out, their histories and their current medication. It is really good".

Our observations of care delivered throughout the home confirmed what people and their relatives had told us. We were satisfied that people received a good service and their needs were met in a timely manner. When we asked staff about specific people's needs they were knowledgeable about these needs and how to support these people effectively. The information they gave us tallied with information held in care records and our own observations. People's general healthcare needs were met and we found evidence people were supported to access routine medical support, or more specialist support, for example, from an occupational therapist, whenever this was necessary.

People's nutritional needs were met and managed well. The senior care worker told us, food and fluid charts were used to monitor that people ate and drank in sufficient quantities to remain healthy. Staff had concerns about one person's weight and had arranged for a GP to visit to review this. People were weighed monthly or more regularly if required, to ensure that any significant fluctuations in their weight were identified promptly and investigated. Any weight losses and gains were clearly recorded and the senior care worker took appropriate action to mitigate the risk of any weight changes. Adapted equipment, such as drinking cups with handles either side, was available where people needed support to maintain their independence whilst eating and drinking. People spoke highly of the food they were given. One person commented, "I am quite happy with the food. It is plain, good, nourishing food" and another person told us, "The food is so good I would much rather eat here than a restaurant!" There was a choice of two dishes at each mealtime and people told us if they didn't like what was on the menu, an alternative meal would be prepared for them. The cook told us they were kept informed by staff about any changes in people's dietary requirements and a file was maintained in the kitchen with details of people's nutritional needs and preferences.

We looked at staff records to establish what training staff had undertaken in their roles. These showed that staff had completed training in key areas such as infection control, moving and handling and fire safety. The findings of our inspection indicated though that staff did not always apply what they had learned, for example, they had not safeguarded people appropriately and there were shortfalls in how staff handled medicines. Staff had also received some training in areas relevant to the needs of the people they supported, such as dementia awareness and nutrition awareness. A basic induction package was in place but this essentially involved shadowing staff and reading through the provider's policies and procedures. The provider told us they had not yet embedded the Care Certificate, which was introduced in April 2015, into their induction programme.

We asked staff if they received regular supervision and they confirmed that they did. Records were available which evidenced this. However, there was no appraisal system in place. Appraisals are important as they are annual one to one meetings between staff and their manager where performance over the year is discussed, plus any training requirements and any other matters of a personal or professional nature. The provider told us that she had not undertaken these, but she would be introducing them once she had drafted the appropriate paperwork.

Staff told us that generally communication in the service was good and they passed messages via a communication book retained in the office or at handover meetings that were held 15 minutes before the end of each shift. Healthcare professionals told us they had no communication issues with the service who always acted on their instructions.

Good

Is the service caring?

Our findings

People spoke very highly of the caring nature and patience staff displayed when delivering care. One person said, "I can't imagine living anywhere else. I like everything; the friendship of the staff, their patience is amazing. They are more polite than I am! They treat me with respect and patience. I don't think one could be in a better place to be honest". Another person told us, "You won't see a better care home than here, we are spoilt! They (staff) are all kind, all nice" and a third person said, "I find all the carers are very pleasant if I need anything".

Relatives were equally as complimentary about the service and staff. One relative commented, "It is wonderful here. We are very happy with the home". People's relatives appeared comfortable with staff and told us they could visit their family members at any time. A healthcare professional said, "There are very good interactions between staff and people. The carers really seem to get to know people".

We observed staff when they supported people. We found their engagements to be respectful, pleasant and polite. We saw staff enquired about people's wellbeing and if they needed any assistance throughout the day. Staff warned people that their food plates were hot and people and staff exchanged pleasantries, thanking each other, for example, when assistance and cooperation was given during a care based task. People were given explanations about care to be delivered in advance. For example, we heard staff explaining to people how they would support them to move into the garden area safely.

Staff had undertaken training in equality and diversity. No people living at the home at the time of our inspection had any specific diverse needs, although each person's care needs were diverse and individual to them. Some people attended the local church and, for those who struggled to access the community, church services were held within the home regularly.

People told us staff supported them to maintain their privacy and dignity when delivering care. For example, one person told us that when staff supported them to bathe they discreetly turned away when the person dried their body. They explained that staff were present in the bathroom only at their choice and they were comfortable and happy with this arrangement, as it made them feel safe in case they needed anything. People were also encouraged to be as independent as possible and many people living at the home were very independent. Some people had adapted drinking cups to enable them to hold the cup independently and take fluids themselves. People had walking aids which enabled them to move around the home freely and several people walked down into the local town to shop.

The provider told us that no people living at the home at the time of our inspection had a formal advocacy arrangement in place. She said that people's relatives tended to advocate on their behalf. An advocate is a person who supports the rights and decision making process for another person, should they need support to make their voices heard. For example, a person with cognitive impairment may need an advocate to act on their behalf, in their best interests.

People told us the service provided person-centred care that met their needs and choices, and in that way

they were involved in the service. There was limited evidence of people's involvement in how the service was run or identifying any improvements that were needed. People were asked for their opinions via questionnaires on a six-weekly basis, but there were no 'Residents' meetings' in place to inform people or to include them more in the service.

Records were stored confidentially in the office of the home and we observed that conversations staff had with visiting healthcare professionals or people about sensitive matters were carried out discreetly or in private.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs and any issues that they raised. One person said, "We are very, very, lucky here. I have everything that I need. I have no complaints at all. I have a bell and when I ring it they come straight away". Another person said, "They (staff) would get a doctor if I needed one". Other comments included, "I can't say there is anything that I am not happy with. There is always someone (staff) to come for a walk with me" and "I have been ill lately and I can't fault how they (staff) have looked after me". Relatives reiterated what people had told us and said they had no concerns or complaints about the service their family member received or how staff responded to them if they needed help or assistance.

Visiting healthcare professionals told us they found the service and staff to be responsive to people's needs and proportionate in their approach. One healthcare professional told us, "Staff are alert to people's needs. Their requests for my input are always justified. It is really good here" and a second professional told us, "They (staff) get in touch with us when needed and it is always appropriate".

At our last inspection we identified shortfalls in recording and the content of individual people's care records. At this visit we found that significant improvements had been made. Care records were individualised and contained information for staff to refer to about how best to support people. They were personalised with information about people's life histories and their likes and dislikes. Pre-admission assessments had been carried out before people started using the service to determine their level of dependency and any risks associated with their daily living. We discussed how these could be expanded to include more detailed information. A summary of people's daily routines split into morning, afternoon, evening and bedtime had been discussed with them and then recorded. Care plans and risk assessments were regularly reviewed and updated to ensure that instructions about the care people needed to receive remained current. People had care plans and risk assessments in place for a range of needs including personal care, mobility and dexterity, continence, social activities, oral health and communication.

Care monitoring tools were used to ensure that people's care was delivered appropriately and changes in their health and presentation were identified promptly. For example, positional change charts and food and fluid monitoring charts were available to be used where people had skin integrity issues or there were concerns about their nutritional intake. People's weights were monitored and any significant changes were reported to the senior care worker, who arranged for appropriate action to be taken and input into people's care to be arranged. During our inspection we saw healthcare professionals had been called to review people's needs in response to concerns that staff has identified. Medication was prescribed to one person as a result, to support improvements in their health. Night time checks were carried out and recorded to ensure that people had everything they needed overnight whilst in their rooms and that they remained safe.

A diary system and communication book was used to pass information between the staff team and changing staff shifts. A verbal handover took place when staff shifts ended and began, and this included transferring information about any outstanding actions to complete and any areas of concern or monitoring of people's conditions. Daily notes were maintained which showed evidence of personal care being delivered, activities people had undertaken, their general mood and any other relevant issues. This showed

that measures were in place to support continuity of care.

People's care was person-centred. Records showed staff were responsive to people's needs and they had involved GP's and specialists in people's care when needed, to promote their health and wellbeing. Activities on offer within the home were limited, but many people were independent and told us they pursued their own activities. Several people accessed the community regularly, either on their own or with visiting relations or friends. Many people sat in the lounge area downstairs and enjoyed time socialising with each other during our visits. Film nights were arranged regularly and people said they enjoyed and appreciated these. Some people said they preferred to stay in their own rooms and it was their choice not to socialise with others. One person said, "I could go downstairs and at times I have, but I am quite happy here in my room. I do puzzles and can phone my friends". Another person said, "I like to do my own thing. (Provider name) got me a colouring book. I find it very relaxing. They do activities on a Friday but I am a very private person". People told us the provider arranged trips but that these had not been as often in recent months.

People were encouraged and supported to make choices for themselves. We heard staff ask people where they wanted to eat their dinner, where they wanted to sit, and what they wanted to do. People told us they were always able to make choices and they had as much control and independence in their lives as possible. One person said, "You get lots of choices. You get to choose everything".

People and their relatives told us they were fully aware of the complaints procedure within the service, but all said they had not had any reason to raise a formal complaint to date. One person commented, "I have never had any reason to complain". A relative told us, "It is wonderful here; we have no complaints". This feedback was confirmed in questionnaire responses that people and their relatives had returned. Where people or their relatives had raised any low level concerns or issues with management, such as laundry going missing, they said that these had been addressed promptly. A complaints policy was in place which contained guidance about how complaints could be made and how they would be handled by the service. There was a complaints book in the home but this had no entries in it. The provider and senior care worker confirmed that no complaints had been received.

The provider had a system in place to gather the views of people and their relatives. This involved issuing questionnaires to people and their relatives on a six-weekly basis. The most recent questionnaire results showed that the feedback received was very positive about the staff, their approach and the food served in the home.

Inadequate

Is the service well-led?

Our findings

The provider is registered with the Commission as an individual who is in day to day charge of the service and as such there is no requirement for her to have a registered manager in post. It was clear that the provider sought to ensure people enjoyed a homely atmosphere and environment and that they knew people well. The provider visited the home daily and engaged with people and staff. She took a 'hands on' approach to food preparation and often prepared meals for people.

People and their relatives said they found the provider pleasant and approachable. One person said, "I feel I could go to her (provider) if I did have a problem. She is easy to talk to and I think she would take it on board. (Provider name) pops in to see me". A relative said the provider was approachable but commented, "Suggestions are sometimes taken on, sometimes not".

At our last inspection we noted the provider was not actively involved in the management and paperwork side of the business, relying heavily on a senior care worker to ensure management aspects of the business were carried out. We discussed this with the provider at that time and she acknowledged she needed to take a more active role in directing staff, monitoring their practice, overseeing the general operation of the service and ensuring that legal requirements were met.

At this visit we found the provider had not engaged in her responsibilities as a care home provider and a senior care worker was responsible for the effective management and operation of the service. The provider had not familiarised herself with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or the Care Quality Commission (Registration) Regulations 2009. Nor had the provider sought out best practice guidance about health and safety matters in care homes, such as Health and Safety Executive publications.

The provider had not registered the service user band of dementia to their registration for this location, despite providing care to people with dementia. A service user band is a category of people with similar specific needs to whom the provider delivers care within their service. We discussed this with the provider and senior care worker and directed them towards the action they needed to take to address this matter and correct their registration with the Commission.

We identified two incidents that had not been reported to the Commission in line with legal requirements. These related to a serious injury that one person had sustained and a granted application to lawfully deprive a person of their liberty. We are dealing with this matter outside of the inspection process.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, entitled Notification of other incidents.

In addition, we found the provider had not displayed within the home the rating given to the service at our last comprehensive inspection of the service in March 2015. This is a legal requirement. The provider told us she was not aware that she needed to display the rating. We are dealing with this matter outside of the

inspection process.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Requirement as to display of performance assessments.

People were supported to access medical services and they had the majority of their day to day needs met, but shortfalls in the management of medicines continued. Since our last inspection the senior care worker had introduced a new medication audit which was thorough, but we saw that this had not been completed since April 2016. The provider told us she did not realise that these audits had not been done in recent months. She told us, "Nobody has told me". The senior care worker explained they had spent less time in the office doing administrative tasks in recent months due to covering staff holidays and sickness. They said nobody else had taken on the role of auditing the service during this time.

Other auditing included checks on the environment, fire safety checks and cleaning checklists. However, these were not thorough audits and there was no evidence that where issues were identified, action had been taken to address these matters. At our last inspection we discussed the benefit of using action plans linked to the findings of checks and audits to drive improvements in the service, but this had not been actioned. The senior care worker told us they were not clear on where their responsibilities ended. They said they had not instigated disciplinary procedures or discussed medication errors with staff of a lower grade, where errors in the administration of medicines had been identified in medication audits. This meant the auditing that was in place was not effective, as although issues may have been identified, they were not always addressed.

A "Quality Assurance Plan" was in place which stated "A proactive approach is taken to introduce quality systems that incorporate audits and feedback so that every part of the home and its services can be evaluated to ensure improvements are continuous. The home has a quality orientated approach with a high degree of quality awareness developed through all levels of staff training and management". This "plan" had not been achieved by the provider, as the quality assurance systems in place within the service did not demonstrate a proactive approach to achieve continuous improvement.

The governance and management oversight of the service was poor. There has been a history of failing to meet legal requirements at our previous two inspections of the service and breaches in regulations continued to be found at this inspection. The provider confirmed that they did not carry out any provider level audits to ensure that the service delivered was good, to review quality assurance systems and processes, and to drive improvements within the service. The provider displayed a lack of knowledge around safeguarding and this had led to some safeguarding matters not being reported externally to the local authority for investigation. The lack of oversight had also resulted in the provider being unaware that auditing had fallen behind, that DoLS applications had been overlooked and that medicines had not been managed appropriately. This showed there was a lack of questioning practice.

No staff meetings were held within the service and the staff appraisal system that had been introduced at our last inspection had not been fully implemented. By their own admission the provider stated this was her fault, as she was responsible for carrying out staff appraisals and had not done them. No staff reward or recognition schemes were in place to recognise staff's contribution to the service and encourage best practice. No residents' and relative meetings were held within the home and, although feedback was obtained via the provider regularly issuing questionnaires to people and their relatives, this was the only feedback channel available for these parties, other than a direct approach to the provider in person.

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

2014, entitled Good governance.

The provider had a mission statement which read, "To provide a homely and caring environment in which residents can and will be encouraged to determine the pattern of their lives". We found this was achieved and people felt very "at home" living at the service. We saw people were encouraged to make their own decisions about their lives and they lived as independently as possible. However, the care they received was not always safe and shortfalls within the service existed, which were either not identified or not addressed.