Hilbre Care Limited

# Hilbre House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 23 and 28 August 2018 and was unannounced.

Hilbre House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hilbre House is registered to provide accommodation and personal care for up to 22 people. At the time of the inspection there were 20 people living in the home.

The last registered manager had left the service in January 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been in post since January 2018 and was present on the second day of the inspection. They had begun the process to apply to the Commission to become registered. Feedback regarding the management of the service was positive. Staff told us they could go to the manager at any time and relatives described the manager as, "Great" and told us they had, "A very caring attitude."

At the last comprehensive inspection in December 2017, the registered provider was found to be in breach of Regulations 12 (safe care and treatment), 17 (good governance) and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated as inadequate and placed in special measures. We completed a focused inspection in February 2018 to check whether the significant risks identified at the last inspection had been addressed and found that they had. The overall rating was changed to requires improvement.

During this inspection we found that not all of the improvements had been sustained and the provider was in breach of Regulations 11 (consent), 12 (safe care and treatment) and 17 (governance).

At the last comprehensive inspection, we identified that the fire risk assessment needed to be updated and were informed a contractor had been commissioned to complete this. At this inspection however, we saw that it had not yet been updated. Systems were in place to monitor the environment, however it was not always safely maintained. We observed a broken dado rail that posed a risk of injury and cleaning chemicals were not always stored securely. This meant that vulnerable people had access to these chemicals which could cause them harm.

Most medicines were stored safely; however, we saw boxes of medicines left out in one person's bedroom and medicines that required storage in the fridge were not kept at the correct temperatures. When people were prescribed medicines as and when they needed them (PRN), there were not always protocols in place to inform staff when to administer them.

We found that DoLS applications had been made appropriately. However, records regarding applications, when they were authorised and were due to expire, were not always clearly recorded, or known by staff. Records showed that consent was not always gained and recorded in line with the principles of the Mental Capacity Act.

Systems in place to monitor the quality and safety of the service were not robust or effective. They did not include all areas of the service provided and those audits that had been completed, did not identify all of the issues raised during the inspection. Meetings took place to enable the registered provider to be kept informed of what was happening within the service.

The Commission had not been made aware of all notifiable incidents, such as those relating to pressure sores of grade three and above.

Staff were supported through an induction when they started in post. Supervisions had taken place this year, however annual appraisals had not been completed. Staff had access to training to support them in their role, although further training was required and had been arranged.

People told us they felt safe living in Hilbre House. They were supported by sufficient numbers of staff who had been safely recruited and had a good understanding of adult safeguarding.

Risk to people was assessed appropriately and actions taken to minimise risk of harm. The manager was made aware of all accidents and incidents, but there was no recorded oversight or review to ensure that any trends or themes could be identified.

People were supported by staff and other health professionals to maintain their health and wellbeing and equipment was available to help meet their needs.

People told us they enjoyed the meals available and always had a choice. Staff were aware of people's dietary needs and preferences and these were met by the service.

People told us staff were kind and caring. We observed staff maintain people's dignity and privacy throughout the inspection and care plans prompted staff to promote independence.

Not all people living in the home had English as their first language and we saw that staff had developed ways to ensure they could communicate with all people and help ensure their views were heard.

Relatives visited throughout both days of the inspection and told us they were always made to feel welcome.

Care plans were in place regarding most people's identified needs. They were detailed and reflected people's preferences in relation to their care and treatment. Care plans were reviewed regularly and updated as people's needs changed.

People told us they had choice about their care and how they spent their day. A staff member told us, "There are no strict rules here. People have their own routine and we just follow it." We saw a number of pets in the home, such as a cat, a budgie and goldfish.

There was a range of activities available to people both within the home and in the local community that were based on how people preferred to spend their time. This included swimming, walks, quizzes and films,

as well as trips out in the new adapted taxi.

The manager was undertaking training to support people effectively at the end of their life. Staff worked with other health professionals during these times to ensure people received the most effective care.

People had access to a complaints procedure and people knew how to make a complaint if they needed to.

The manager had developed links with external agencies such as the GP and pharmacy to help ensure joined up care is provided. They had also made links with a local school and a choir had visited the home to sing to people.

## 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.

The environment was not always safely maintained.

Not all medicines were stored safely and PRN protocols were not always available.

People told us they felt safe living in Hilbre House. Staff had a good understanding of adult safeguarding and how to raise any concerns.

Risk to people was assessed appropriately and actions taken to minimise risk of harm.

There were sufficient numbers of staff on duty to meet people's needs in a timely way and they were recruited safely

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Systems in place to monitor applications to deprive people of their liberty were not robust. Records showed that consent was not always gained and recorded in line with the principles of the Mental Capacity Act.

Staff were supported through induction and supervisions; however annual appraisals had not been completed. Staff had access to training, although further training was required and had been arranged.

People were supported by staff and other health professionals to maintain their health and wellbeing.

People told us they enjoyed the meals available and always had a choice. Staff were aware of people's dietary needs and preferences and these were met by the service.

### Is the service caring?

**Good**

The service was caring.

People told us staff were kind and caring and we saw staff provide support in ways that protected people's dignity and privacy.

Not all people had English as their first language and staff had developed ways to ensure they could communicate with all people.

Relatives visited throughout both days of the inspection and told us they were always made to feel welcome.

It was clear that staff knew the people they were supporting well.

## Is the service responsive?

**Good**

The service was responsive.

Care plans were detailed and reflected people's preferences. They were reviewed regularly and updated as people's needs changed.

People had choice about their care and how they spent their day.

There was a range of activities available to people both within the home and in the local community.

Staff worked with other health professionals to support people effectively at the end of their lives.

People had access to a complaints procedure and people knew how to make a complaint if they needed to.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not robust or effective.

The Commission had not been made aware of all notifiable incidents, such as those relating to pressure sores of grade three and above.

Meetings took place to enable the registered provider to be kept informed of what was happening within the service.

Policies and procedures were available to guide staff in their role and team meetings were held to enable staff to share their views

of the service.

# Hilbre House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 23 and 28 August 2018 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We reviewed information sent to us by the public and we also contacted the commissioners of the service to gain their views.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the manager, and six other members of the staff team, including the chef and administrator. We also spoke with four people living in the home and three relatives who visited during the inspection.

We looked at the care files of six people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various times during the inspection.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe living in Hilbre House and relatives agreed that their family members were safe and well cared for. One person living in the home told us they were, "Safe as houses."

Systems were in place to monitor the environment and equipment. For example, external contracts were in place to make regular checks on the gas, electricity and fire safety systems. Records showed that regular internal checks were also completed in areas such as water temperatures, fire doors, fire alarms, profiling beds and water outlets were flushed regularly.

We found however, that the environment was not always maintained to ensure people's safety. For instance, we observed a broken dado rail in one person's bedroom that was close to the head of their bed and posed a risk of injury. This was reported to the maintenance team on the first day of the inspection. On the second day we saw that it was still broken. We were informed it has been repaired but had been broken again over the weekend. It was repaired again on the second day. We also saw that cleaning chemicals were stored in an open bathroom. This meant that vulnerable people had access to these chemicals which could cause them harm.  We raised this during the inspection and they were removed straight away.

At the last comprehensive inspection, we identified that the fire risk assessment needed to be updated and were informed a contractor had been commissioned to complete this. At this inspection however, we saw that it had not yet been updated, although a new contractor was booked in to visit the service in September 2018.

We looked at how medicines were managed in the home. Most medicines were stored in a locked trolley; however, we saw boxes of prescribed medicines left on a unit in a bedroom. This meant they were accessible to anyone who entered the room. We also found that the temperature of the medicine fridge was a lot higher than the recommended range for medicines that require refrigeration. The high temperatures had been recorded by staff each day for the month of August, but there was no evidence that any action had been taken to address this. When we spoke with staff, it was clear that not all staff understood what the safe temperature ranges were. If medicines are not stored at the correct temperature, it can affect how they work.

We found that risk assessments had not been completed when people were self-administering their medicines, to ensure they were able to do this safely. Medicine administration charts (MARs) showed that some people required their medicines to be administered as and when they required them (known as PRN). There was however, no guidance available to inform staff when they should administer the medicines. For instance, one person was prescribed a medicine to help them when they became agitated and they could have it up to three times a day if they needed it. There was no protocol to guide staff what to look for to establish whether the person required the medicine. This meant that they may not receive it consistently, or when they required it.

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

2014.

Staff had a good understanding of adult safeguarding, what constitutes abuse and how to report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the home. This enabled referrals to be made to the relevant organisations and helped to ensure people were protected from harm.

There was a whistleblowing policy in place and staff were aware of this. Whistleblowing is where staff can raise concerns either inside or outside the organisation without fear of reprisals. This helps maintain a culture of transparency.

People were protected from discrimination as a clear equality and diversity policy was in place and staff were all aware of this. The policy reflects that both staff and people living in the home would be treated equally, whether or not they had any of the protected characteristics defined in the Equality Act 2010.

Care files showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place, such as regular weight monitoring or pressure relieving equipment. Risk assessments specific to individual's needs were also in place, such as bed rail assessments. Personal emergency evacuation plans were also available and these provided clear information in what support people would require in the event of an emergency.

We looked at accident and incident reporting within the home. We saw that all accidents were recorded electronically on people's individual care records and it was clear that appropriate actions were taken following any incidents. For example, one person's file showed that they had been found on the floor in their bedroom. They did not sustain any injury but to prevent further falls and possible harm, an assessment was completed for the use of bed rails and they were put in place.

The manager was made aware of all incidents, but there was no recorded oversight or review to ensure that any trends or themes could be identified. We discussed this with the manager who acknowledged that monthly reviews of all incidents would be beneficial and that they would implement this to help identify any areas that could be improved to prevent further incidents.

We looked at how the home was staffed. On the first day of inspection there were three care staff, a domestic, a chef and office staff supporting 20 people living in the home. We viewed staff rota's and saw that these staffing levels were maintained. Staff told us that there were enough staff on duty to meet people's needs in a timely way and people living in the home did not raise any concerns about the staffing levels. Staff told us they covered if people were on holiday or off sick and that agency staff were not used, to help ensure consistency for people living in the home.

We looked at how staff were recruited within the home. We looked at three personnel files for staff who had recently been recruited. We found evidence of application forms, photographic identification and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. All the files contained references, although one person's references had not been verified. We raised this with the manager who agreed they would ensure all references were verified.

The home was clean and an infection control policy was in place. This included clear guidance on how staff should manage any outbreaks of infections within the home. We saw that personal protective equipment, such as gloves and aprons was available to staff and used appropriately. Bathrooms contained liquid hand soap and paper towels in line with infection control guidance. This helped to prevent the spread of infections.

Requires Improvement

# Is the service effective?

## Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that DoLS applications had been made appropriately. However, records regarding applications, when they were authorised and were due to expire, were not always clearly recorded, or known by staff. For instance, we were told that a person had a DoLS authorisation in place, however the records we viewed showed it had expired. There was no record of a new application being made, however the local authority was able to confirm it had been submitted by the provider and was waiting to be authorised.

Staff we spoke with had a good understanding of the MCA and told us they had received training regarding this. However, records showed that consent was not always gained in line with the principles of the MCA. For instance, one person's file did not contain any consent forms in relation to their care and treatment. A second person's file contained a medicine consent form that had been signed by a member of staff who had no legal authority to consent on behalf of the person. A third person's file reflected that their family members agreed it was in the person's best interest for staff to administer medicines to the person, but there was no mental capacity assessment to establish whether the person had the capacity to make this decision for themselves.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported in their roles and could go to the manager at any time if they had concerns. Records showed that supervisions had been completed for staff earlier in the year and we saw that they had been scheduled in for all staff on the electronic system. The system alerts the manager when supervisions are due. Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Although it was evident that supervisions took place, there was no records regarding annual appraisals and the manager told us they had not completed any since being in post.

We looked at staff training records and found that most staff had completed training in areas such as moving and handling, safeguarding, fire safety, nutritional needs, control of substances hazardous to health and mental capacity and DoLS. There was no record of medicine training, however we did view this at the last comprehensive inspection in December 2017. The manager told us the person who had arranged

training and maintained the records had left the service since the last inspection and the manager no longer had access to those records. The manager had booked training in September and October, which included food hygiene, dementia care, first aid and infection control.

Staff told us they received sufficient training and could request to attend any additional course they felt they needed. The manager told us they had recently subscribed to an online training resource that all staff will have access to. When staff started in post they completed shadow shifts with more experienced staff to help them become familiar with people living in the home and how they liked to be supported. They also completed a basic induction to the safety of the building, although records of this were not available in all staff files.

Care plans we viewed showed that people's needs were assessed, including their mental, physical and social needs. This showed that people were assessed holistically as individuals and plans were in place to meet their identified needs. We saw that people's needs were assessed prior to them moving into the home. This ensured their needs were known and could be met from the day they moved in.

Care files also reflected that people were supported by the staff and external health care professionals to maintain their health and wellbeing and meet their needs. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, dietician, optician, speech and language therapist and social worker. Advice was sought in a timely way when any concerns were identified. For instance, one person's file showed that they had developed a sore and itchy rash on the day of the inspection and the GP had already been contacted for advice. A relative told us, "[Name] is in better health now than she was at home."

An electronic virtual nurse system had been implemented which would enable staff to access healthcare advice. However, due to connectivity issues, this was not in use at the time of the inspection. Other types of equipment were in place to support people living in the home, such as a hoist, wheelchairs, evacuation mats and sensor mats to alert staff when people mobilised that were at high risk of falls. This helped to ensure people's needs were met safely and to prevent potential injuries.

We observed lunch in the dining room on the first day of the inspection. A choice of meal was available and people told us they enjoyed the food. We saw that relatives were welcome to join their family members for lunch if they chose to. One relative told us their family member's weight and diet was better since living in the home. Another relative told us the chef bought specific foods to cater for their family members dietary preferences.

The chef was knowledgeable regarding people's needs and preferences and told us he used this information to create the menus with people's input and feedback. The chef provided a range of specialised diets, including diabetic, fortified and blended diets. They also provided diets to people based on their cultural preferences and a family member told us they did this very well. We observed the chef speak to people in the dining room to enquire if they had enjoyed their lunch.

Risk assessments were in place in relation to malnutrition and we saw that actions were taken when people were at risk. Diet and fluid charts were maintained when required, however we saw that these were not always analysed at the end of the day to ensure adequate diet and fluid had been taken. People were given additional fortified snacks if there was a concern regarding nutritional intake or weight loss. When advice from the dietician was sought, we saw that this was incorporated into people's plans of care. This helped to ensure that all staff knew how to best support the person.

We observed the environment of the home and found that it was suitable to meet the needs of the people who lived there. The home was well lit with wide walkways to help people mobilise safely. People could personalise their bedrooms and for people who were living with dementia, there were photographs, names and numbers on bedroom doors to help maintain independence and orientation. A large lounge and dining room were available for people to spend time together in. They were bright and airy and provided nice views.

Good

# Is the service caring?

## Our findings

People living in Hilbre House told us staff were kind and caring and treated them with respect. Their comments included, "They are like my family. They are brilliant", "I am wonderfully well looked after", "Staff are kind and helpful", "Fabulous" and "All staff across the board are lovely and look after us." Relatives agreed and told us, "[Name] loves the carers", and that they are "Very helpful." Another relative told us, "This place is great" and that staff had "A very caring attitude."

During the inspection we observed staff maintain people's dignity and privacy, by knocking on people's bedroom doors before entering and providing personal care in private areas with doors closed. Staff told us they always worked in ways to protect people's dignity, such as using towels to cover people when providing personal care. Care plans were written in a respectful way and reminded staff to provide explanations of any support provided, to always introduce themselves and to promote people's independence.

We heard staff speak to people in a warm manner and in a way that people could understand and it was clear through discussions, that staff knew the people they were caring for well. For instance, one staff member could clearly explain the dietary needs of a person who required a specialised diet and their drinks thickened to help prevent any choking episodes.

Not all people living in the home had English as their first language and we saw that staff had developed ways to ensure they could communicate with all people. A staff member was able to converse with one person in a language they both understood and the manager told us staff would often use a translation app to help ensure the person's needs were known. A relative told us staff had got to know their relative so well they were able to communicate their needs and preferences without needing a lot of verbal communication. The manager told us that staff had at first used picture cards to help communicate everyday needs, such as shower, use of the toilet, drinks and meals.

The manager was also aware of resources available to support people who have visual impairments, such as talking books. They had supported one person to access a talking newspaper to help maintain their interest in this. They also told us that documents such as the service user guide, could be provided in large print if required.

When people moved in to the home they were provided with a service user guide and other relevant information regarding the home. This included information on what services people could expect when they moved in, what is included in the monthly fees, the aims of the service, staffing information, meals, care planning, involvement activities and how to make a complaint. This showed that people were given information and explanations regarding the service to enable them to be involved and make their own informed decisions.

For people who required support to make decisions and did not have friends and family to assist them, the manager was aware of advocacy services and told us they would support people to access these services whenever needed. An advocate is a person that helps an individual to express their views and wishes, and

help them stand up for their rights.

People told us they were involved in their care plans and that they were happy with the care that they received. Care plans provided detailed information about people, including their preferences in areas such as activities, meals and daily routines, which showed people had been involved. Relatives told us they were always kept updated if there was any change to their family members health and wellbeing and staff explained that they were made aware of any changes through daily handovers.

We observed relatives visiting throughout both days of the inspection. The manager told us there were no restrictions in visiting, encouraging relationships to be maintained.  Relatives often joined their family members for meals or joined in with activities and told us they were always made to feel welcome by staff.

Care plans were stored securely electronically in order to maintain people's confidentiality in line with the Data Protection Act. However, people's paper records, such as correspondence from health professionals, were stored in an office that was not locked when unoccupied. The manager agreed to ensure these records were also stored securely.

Good

# Is the service responsive?

## Our findings

We looked at care files and found that care plans were in place in areas such as mobility, personal care, communication, nutrition and cognition. There were also plans in place regarding people's health conditions. For example, one person had a diabetes care plan in place. This provided information on what support the person required to manage their diabetes and signs and symptoms to look for which may indicate that the condition is not well controlled and medical advice may be required. Most plans were detailed and focused on the individual. This helped to ensure that staff had guidance on each person's needs and how they could meet them.

We found however, that additional plans could be implemented to ensure that there were plans for all identified needs. For instance, one person who had an authorised DoLS in place, did not have a care plan to inform staff it was in place, when it expired and what the conditions of the authorisation were. Another person's file showed that they had a medical condition that could cause breathlessness and treatment was available in the home when needed. Although staff were knowledgeable regarding the person's needs, there was no plan of care to guide staff when this treatment should be provided.

Care plans reflected people's preferences in relation to their care and leisure activities, helping staff to get to know people as individuals and enabling them to provide support based on people's needs and preferences. For instance, one person's care file reflected that they really enjoyed talking about their family members. It advised that the person had many photographs in their room and this was a good way to engage the person and prompt conversations.

Care plans had been reviewed regularly and updated as people's needs changed. For instance, one person had been assessed by the speech and language therapist who recommended the person had their fluids thickened and their meals pureed to assist with safe swallowing. This information had been transferred to the person's nutrition care plan, so staff had up to date information regarding the person's needs.

We saw that pre- admission assessments were usually completed prior to people moving into the home. This ensured the service was aware of people's needs and that they could be met effectively from the day they moved in.

People told us they had choice about their care and how they spent their day. For instance, people agreed they could get up and go to bed whenever they wanted to. Staff told us they assisted people to shower or bathe at the times and frequencies that each person preferred. One staff member told us, "There are no strict rules here. People have their own routine and we just follow it."

We saw a number of pets in the home, such as a cat, a budgie and goldfish. The manager told us if they could safely accommodate it, people could bring their pets with them when they moved in.

We looked at activities available and how people's social needs were met. We saw that some people liked to spend time in the lounge and one person was lying on a sofa watching television, whilst another person was

reading a newspaper. Two people had their television channels streamed from the internet in their first language so that they could continue to watch and enjoy programmes familiar to them.

Two activity coordinators were in post and provided a schedule of regular activities. These included walks on the beach, quizzes and films. The manager told us they had ordered a projector for cinema screenings as some people had enjoyed visiting a local community centre cinema but this had now stopped.

We found that there was a variety of activities available based on people's preferred leisure activities. For example, one person was supported to go swimming each week, there were coffee mornings, piano music in the lounge and trips to the local church for soup and a sandwich. A new taxi had also been purchased recently and this enabled more people to be involved in the trips out to places such as Parkgate for an ice cream, shopping in Cheshire Oaks and the Christmas pantomime.

Regular communion was available in the home and the manager told us they had arranged for a blessing for a person who was nearing the end of their life. The manager was undertaking training to ensure they could effectively support people at the end of their lives and told us they would be arranging additional training for all staff members. The staff work with family members and other health professionals, such as the GP and district nurses to help ensure that appropriate support is provided to people and their relatives during this time. They also offer meals and accommodation for family members who wish to stay near to their relative at this time.

One person's care file reflected that they had discussed their end of life care wishes with staff and had a plan in place to reflect this. However, no other care files viewed contained information to show people's preferences or plans had been discussed in relation to their end of life care.

People told us staff were always available to support them in a timely way. Some technology was in use to ensure people received care at the time that they needed it. For instance, call bells were available to ensure people could call for help when they were in their rooms.

People had access to a complaints procedure and this was displayed on a notice board within the home, as well as in the service user guide. Relatives we spoke with told us they knew how to make a complaint if they needed to and felt that their concerns would be addressed. A complaints log was maintained which showed that three complaints had been received since the last inspection and had been investigated and responded to in line with the provider's policy.

Requires Improvement

# Is the service well-led?

## Our findings

We looked at the systems in place to monitor the quality and safety of the service. At the last inspection the manager told us a new audit schedule was being implemented to ensure adequate monitoring of the service. During this inspection however, we found that the systems in place still required further development as it was not effective. For instance, there were no audits in place to review care plans, recruitment records or accidents and incidents. These are significant areas that require oversight. The current systems did not identify that checks in place to monitor people's diet and fluid intake, were not being analysed to ensure people received their recommended amounts.

Completed audits were not effective as they did not highlight all the issues we identified during the inspection. We viewed medicine audits for June and July 2018. These were not fully completed and did not reflect the concerns regarding ongoing high fridge temperatures or the lack of PRN protocols. The environmental audits did not identify chemicals that were not stored safely, or the damaged dado rail.

Health and safety audits were completed monthly, but did not identify any issues within them. However, the manager told us that the audits did highlight areas for improvement that they had acted upon, such as the need for new flooring in some areas, which had been fitted. Not all audits identified what was being looked at as part of the audit, but just recorded the outcome. We discussed this with the manager who explained they were completed based on the knowledge and experience of the person who completed them. This meant that there was not a robust system in place to ensure the quality and safety of the home was monitored. The manager agreed that it would be difficult for them to maintain effective oversight from the audits that were in place at the time of the inspection. They hoped to further develop the audit system with new comprehensive electronic systems in the future, which could be completed by any staff member.

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

Regular manager meetings were held which the provider attended. Records showed that key issues and developments within the service were discussed. This helped to ensure the provider was aware of what was happening within the home and able to maintain an oversight of the service.

The service had notified the Care Quality Commission (CQC) of some events and incidents that occurred in the home in accordance with our statutory requirements. However, we found during the inspection that we had not been made aware of all notifiable incidents, such as pressure sores of grade three and above. We discussed this with the manager who told us as the district nurses managed most wounds, they were not always informed of the grade of the wounds. They agreed to discuss this with the district nursing team to ensure they were always made aware of any notifiable incidents.

The last registered manager was no longer in post and a new manager had been appointed and in post since January 2018. They had begun the process to apply to the Commission to become the registered manager. Feedback regarding the management of the service was positive. Staff told us they could go to the

manager at any time and relatives described the manager as, "Great" and told us they had, "A very caring attitude."

Policies and procedures were available to guide staff in their role. Staff told us they were aware of these policies and the manager told us they advertised specific policies or guidance on a regular basis. We saw that the manager had provided staff with a copy of the code of conduct to read and sign, as well as the Skills for Care "developing resilience in the workplace" document, to support staff wellbeing. The manager told us they had joined the Skills for Care manager network and now received regular updates and good practice guidance.

Staff told us they worked well together as a team to ensure everything ran smoothly and people's needs were met. A recent team meeting had been held in July 2018 and records showed that staff were asked for their views of the service and encouraged to raise any issues. There were no resident and relative meetings held and the manager told us this was because when they had arranged them, nobody came. They felt this was because they had an open-door policy and both people living in the home and their relatives, raised any issues or views as and when they occurred.

Ratings from the last inspection were displayed within the home as required. The provider's website also reflected the current rating of the service. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

The manager had developed links with external agencies such as the GP and pharmacy to help ensure joined up care is provided. They had also made links with a local school and a choir had visited the home to sing to people.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>Consent was not always gained in line with the principles of the Mental Capacity Act 2005. Systems in place to manage and monitor applications to deprive people of their liberty were not robust. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The environment was not always safely maintained.<br>Medicines were not always managed safely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems in place to monitor the quality and safety of the service were not robust or effective. |