Wolfe House Limited

Wolfe House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1 November 2017 and was unannounced.

Wolfe House Care Home is a home that provides accommodation and personal care for up to 13 people. The majority of people at the home were living with dementia. At the time of our inspection there were 10 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, we did identify areas in which the provider was not meeting their legal requirements.

Although people received responsive care, people's care records were not contemporaneous. Quality assurance audits were carried out, but some evidence of audits were not recorded. Staff did not always follow the requirements of the Mental Capacity Act 2005 although staff were able to demonstrate to us their understanding of it.

People were not always shown respect by staff or encouraged to be independent. However, we did find staff caring and kind. People were happy living in the home and we found the environment was clean, hygienic and homely. The registered provider was carrying out works on the home to help improve the environment for people with poor mobility or living with dementia.

People's medicines were managed safely. Important information about people's healthcare needs and medicines were recorded in their care plans. Staff worked alongside healthcare professionals to meet people's health needs. Where any accidents, incidents or infections occurred, staff took appropriate action in response to them; however we found that this was not always recorded.

People were cared for by sufficient numbers of staff. We did not see people having to wait to receive care or support. Appropriate checks were carried out when recruiting staff to ensure that they were suitable for their roles. Staff were aware of their responsibilities in relation to keeping people safe. Both in respect of keeping people safe from harm because individual risks had been identified and also in respect of signs of abuse. People were comfortable with speaking with staff if they had any concerns.

There was a procedure in place to help ensure that people were kept safe in the event of an emergency. People lived in a safe environment. Even though there was a large amount of building work going on staff had undertaken a risk assessment to ensure people were kept free from harm. Regular checks were made on equipment and services within the home to check they were well maintained.

People were provided with food that matched their preferences. People had access to activities that suited their needs and to help ensure they did not feel isolated. People's individuality was recognised by staff and as such staff supported people in relation to their personal needs. People's needs were assessed before they moved into the home to help ensure they received appropriate care.

The registered manager created a positive culture and staff felt supported by her. Although there was a clear management structure in place it was evident that all staff worked together as a team. The registered manager was very hands on throughout the day. Staff received training appropriate to their roles and the provider's values. Staff benefitted from regular supervision and appraisals.

During our inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made one recommendation to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received the medicines they required.

People were cared for by a sufficient number of staff who had gone through a formal recruitment process before commencing work.

People lived in a home which was free from infection.

People were kept free from harm as staff understood their safeguarding responsibilities and risks to people had been identified.

Where accidents and incidents had occurred staff took action to help ensure these did not reoccur.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's legal rights were not always protected because staff did not always work in accordance with the Mental Capacity Act (2005).

People were happy with the food they received.

Staff followed the guidance of healthcare professionals to meet people's needs. People had access to healthcare services when they required it.

Staff received appropriate training and supervision for their roles.

People's needs were assessed before moving into the home in order to help ensure these needs could be met by staff.

People lived in an environment that was undergoing refurbishment to provide them with suitable premises to meet their needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's independence was not always promoted by staff.

People were not always treated in a respectful way by staff.

People's privacy and dignity was maintained by staff.

People were treated with kindness by staff and relatives were welcomed into the home.

Is the service responsive?

Good

The service was responsive.

People received responsive care.

People's concerns and complaints were listened to.

People had access to activities to help ensure they were not isolated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Contemporaneous records were not held for each person.

Quality audits were not robust and evidence of some audits taking place were not written down.

The registered manager promoted a positive culture within the staff team and staff felt supported by her.

There were systems in place to monitor the quality of the care that people received.

People were involved in the running of the home and the provider showed a commitment to improve the service for people.

The registered manager was aware of their statutory requirements and duties in relation to CQC.

Wolfe House Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 November 2017 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we gathered information about the service. We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with four people, one relative, the registered manager and three staff. We observed caring interactions between people and staff. We reviewed the care plans for four people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at five staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of meetings of staff, people and relatives.

Following the inspection we received feedback from one professional who visited the home.

Our last inspection was in November 2015 in which we gave the home a 'Good' rating.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the home. One person told us, "I have had no issues with staff." A relative said, "I feel she is safe. It's just the feel of the place. Staff are very patient."

People were cared for by staff who were aware of their responsibilities in relation to safeguarding people. The provider had stated in their Provider Information Return (PIR), 'staff recognise signs of abuse and are aware of procedures' and we found this to be the case. Staff were able to describe to us the different types of abuse and knew what to do if they suspected any. One staff member said, "Through observation, report bruising or marks. Bruising could be a sign of being heavy handed. I would report it to [the registered manager] and the local authority needs to know." A second told us, "It's about looking after people properly, looking for things that are not right that might flash up. The way they are, their behaviour." We found the registered manager was knowledgeable in their duty to notify us of any safeguarding concerns or allegations of abuse. People told us they felt comfortable raising any concerns they had. One person told us, "I have nothing to worry about here."

People's personal risks were assessed and plans were in place to manage them. Records in relation to people's risks were up to date and available to relevant staff. The home was undergoing a significant amount of building work as a two storey extension was being built. As such the registered manager had carried out a full risk assessment in advance of the building work commencing to help ensure people were kept free from harm. Where accidents or incidents occurred, staff learnt from these and took appropriate action to help prevent them from reoccurring. For example, people had alarm mats in their bedrooms to alert staff if they got out of bed. One person remained in their room at all times and staff checked on them every hour. Another person's care plan stated they were at risk of falls. Action taken had been to introduce the use of a Zimmer frame and two care staff would support the person when transferring from sitting to standing. We saw this person received the level of support in line with their care plan during the day. A staff member told us, "We look at how the environment is set up. There are usually staff on the floor at all times. If they (people) get up and wander, we will follow them. We make sure that shoes fit on properly and that hazards are cleared away."

People were cared for by a sufficient number of staff who had the right skills. The staffing rota showed that a senior staff member was on duty each day. This was usually the registered manager or deputy manager. The registered manager was seen on the floor working with staff to ensure they were following good practices. We did not see or hear anyone having to wait for staff support and staff presence was felt continuously throughout the day. Where people required two staff members to walk with them we saw this happening on all occasions. Staff training records showed that staff received a wide range of statutory training before commencing in their role. We observed staff acting in a competent manner. One person told us, "There are always staff around." A staff member said, "I feel two carers are enough. We can see and hear them (people)." A second told us, "I feel there are enough staff. There are always plenty of us. We manage to get everything done." A relative said, "They are never short of staff."

People received the medicines they required. We saw each person had a Medicine's Administration Record

(MAR). This had an up to date photograph of the person for identification purposes, any allergies they were subject to and any other relevant information in relation to their medicines. We did not identify any gaps or mistakes in the MAR records. We did find however that not everyone had a PRN (as needed) medicine protocol in place, although not everyone was on PRN. We discussed the importance of these guidelines for people living with dementia with the registered manager. This is because people living with dementia may be unable to communicate that they require pain relief. The registered manager was able to evidence that they had a PRN protocol available and that they would complete this for each person. In addition, the registered manager showed us a homely remedies (medicines purchased over the counter without a prescription) protocol which they used when people required this type of medicine. The registered manager told us they had a good relationship with their local GP practice should they have any queries regarding either PRN or homely medicines. People told us they got the medicines they needed. One person said, "My medicines have all changed, but I've spoken to the memory person about that."

People lived in an environment that was clean and hygienic. Staff were knowledgeable in infection control procedures and we observed housekeeping staff undertaking cleaning tasks throughout the day. Despite the considerable building work taking place, the home was free from dust and any other airborne risks associated with building works. We asked staff about the prevention and control of infection in the event a person may have sickness. One staff member said, "We would contain someone in their room. We would use aprons and gloves and sterilise any equipment afterwards." A relative told us, "The home is always clean. Never seen a problem with cleanliness."

People were kept safe from being cared for by inappropriate staff because the provider carried out checks on all new staff that they recruited. The provider told us in their PIR that they undertook Disclosure and Barring Service (DBS) checks and took up two references for potential staff. We found evidence of this in the staff files we reviewed. In addition there was evidence of work history, a health declaration and a right to work in the UK. DBS is the Disclosure and Barring Service which helps to ensure prospective staff are suitable to care for people in this type of setting.

People were kept safe in the event of an emergency. People had personal emergency evacuation plans (PEEPs) in place. These reflected people's needs and provided staff with information on how to best support them in the event of an emergency. For example, they included information about one person who had a hearing impairment to show this person may need to be spoken to in a louder voice during an emergency. The home had assessed risks such as fire and all equipment for use in the event of an emergency was regularly serviced. We saw an updated fire risk assessment that took place when the external fire staircase was removed at the start of the building work. We noted that staff had signed to say they had read the updated risk assessment to show they were aware of the new arrangements for evacuation. The home had a plan for what to do in the event of an emergency to ensure that people were kept safe and their care needs could be met. Regular fire alarm tests and drills took place; particularly following the onset of the building work. There was a contingency plan in place which showed that staff would liaise with other local care homes to accommodate people if the need arose. Staff knew what action to take in the event of a fire. One staff member told us, "We would get everyone to an assembly point and whoever was in charge will do the checks to see where the fire is coming from."

Staff understood their responsibilities to raise concerns and take effective action to respond to any events to improve the service to people. We noted from the records we reviewed prior to the inspection that one person had developed a pressure sore. We read that staff had responded to this by liaising with appropriate healthcare professionals, providing appropriate pressure relieving equipment and following guidance in order to help ensure this person was repositioned and topical creams applied to maintain their skin integrity.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

People's legal rights were not always protected because staff did not always follow the guidance of the Mental Capacity Act (2005). Records for people did not contain evidence of decision-specific mental capacity assessments in situations where people were unable to make decisions for themselves. For example, one person's bedroom was being used as the staff room whilst the building work was underway. The registered manager told us that the person's family had been consulted and they were happy with this arrangement. However, we found no evidence that the person had been consulted in this and that a mental capacity assessment or best interests discussion had taken place to help ensure that this was the best decision for this person. Another person's family had made the decision on their behalf that the person should not have a flu jab. However, we found no evidence of this family member having the legal authority to do this and furthermore no capacity assessment or best interests discussion had taken place. Other people had sensor mats beside their beds which was a restriction of their liberty and yet decision-specific capacity assessments had not been carried out in relation to these.

The failure to follow the requirements of the Mental Capacity Act (MCA) 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood the principles of the MCA. One staff member told us, "It's about when people need to make a decision and assessing their capacity (to do so). You always assume they have capacity. If I was in any doubt I would speak to [registered manager]." They followed by saying, "Best interest meetings should involve families or an advocate and GP if needed." A second staff member said, "We may need to make a decision for them if it's safer if they lack capacity." We heard staff asking people for their consent before carrying out any care for them. For example, staff asked one person if they would like help with cutting up their food.

People told us that they liked the food that was prepared for them. One person told us, "The food is very good." Another told us, "The food is marvellous." We saw people have tea and cake in the afternoon and one person commented on how, "Lovely" the cake was.

People's dietary needs were met. Care records contained important information about people's dietary needs and how best to meet them. One person required adapted cutlery to enable them to eat their meal

independently and we saw they were provided with this at lunch time. People could choose where to take their meals and we saw some people eating together in communal areas, whilst the choice of others to eat in their room was respected. The chef knew people well. They knew their likes and dislikes. They were able to tell us that one person did not like eggs and another was diabetic. They told us, "We have meetings with them (people) and they come up with ideas." We saw that the meal was freshly prepared and the chef told us they made cakes and biscuits from scratch for people. A staff member told us, "The food is good. They (people) have a big variety and are always given an alternative." They told us they would look out for someone who was not eating as this could be a sign that they were unwell.

People had access to a GP and other healthcare professionals. Staff worked well across organisations to deliver effective care and seek treatment for people. The provider told us in their PIR, 'positive relationship between the health care professionals including GPs, district nurses and other health care teams made the quick referral to health care teams without any delay'. We saw evidence of this as staff were reporting any concerns that they had to external health care professionals. We saw evidence that people had access to a chiropodist, dentist and optician and the registered manager had liaised with the local GP practice to arrange flu jabs for people if they wished them.

People were supported to access healthcare services and receive ongoing healthcare support. For example, one person regularly accessed an audiologist to check their hearing aids. We saw another person was supported to regularly attend the diabetic eye clinic for screening. A relative told us, "[Registered manager] keeps us posted. If she needs any treatment she lets us know."

People's needs were assessed prior to moving in to Wolfe House to help ensure that staff could meet the needs of the person. The assessment captured important information about people's needs and backgrounds. This information was added to care plans and reviewed monthly. Staff worked closely with external healthcare professionals and took their advice and followed their guidance when appropriate. This meant people's care was delivered in line with best practice. For example, in relation to one person who had been seen by the mental health team.

People were supported by staff that were trained to meet their needs. Staff said they completed a selection of mandatory training courses when they started, such as health and safety, infection control, safeguarding and first aid. One staff member told us, "It's (the training) good. The trainer is very thorough and passionate." The staff member was able to describe to us the different types of dementia. They said, "I try to put myself in their place." Another said, "I felt I had enough training."

Staff training included equality and diversity courses and records showed these had been attended by all staff. One person living in the home was much younger than the rest. As such staff had supported this person to enrol in the befriender scheme and they now had a befriender visit them regularly in the home for a chat.

When staff commenced work at the home they underwent an induction. We saw staff being inducted on the day of our inspection. One staff member said, "I had a very good induction. I had a trial with [deputy manager]. She gave me the basic information about people. I shadowed for two to three weeks. I wasn't left on my own with anyone until I started my training."

Staff had the opportunity to meet with their line manager for supervision. Records showed that these sessions were used to discuss people's needs as well as staff learning and development. Although staff did tell us that as it was a small workforce and the registered manager was hands on they talked all the time together. We saw this happen on the day.

People lived in an environment that, on the whole, was adapted to meet their needs. However, this would be further improved as the provider had commissioned works to the building which would enhance the environment and its suitability for people with poor mobility or living with dementia. Wet rooms were being installed, rather than people trying to access a bath and the lounge and dining area were to be made more spacious and open to give people additional space to move around. We saw one person had a telephone in their room which had large buttons with clear numbers on it. There was a stair lift for people with rooms on the first floor to be able to access them. We noted equipment was checked regularly, such as hoists, the chair lift and people's mobility aids.

Requires Improvement

Is the service caring?

Our findings

People told us that they were supported by caring staff. One person told us, "They do what they can here. The girls are wonderful." Another commented, "The staff are kind. It is very nice here." A further person said, "I am very happy here." A relative told us, "Staff here are genuine. Staff are very nice, very patient." A professional told us, "I can only say that when I am at Wolfe House I have found the residents to be treated kindly by the staff."

During the inspection we observed kind and pleasant interactions between people and staff. However, we found staff did not always consistently show respect towards people. The provider had told us in their PIR, 'ensure that all staff work with the manager and senior staff to ensure that the identified needs are met in a way which promotes dignity, choice and independence'. We did not always observe this during the day. We heard several occasions throughout the day when staff spoke about people to each other whilst in front of them. Following lunch staff sat together on their break and discussed one person and how they had eaten their lunch. This person was sitting in the room next to staff and could have easily heard this conversation. At other times staff sat together in the lounge and talked to each other rather than making conversation with people sitting in the room.

People were not told what they were being given for lunch as we watched staff put plates of food in front of people without saying anything. We overhead staff discussing what the meal was and not all knew it was pork. Once lunch was served we saw three staff members standing leaning up against the dining room wall observing people eat. This gave a sense of staff 'patrolling' people. We spoke with the registered manager about this and asked them to consider a less obtrusive way for staff to be present in the dining room. They told us space was an issue in that there was insufficient room for staff to sit with people, but said they would look at different ways of ensuring staff presence but in a more relaxed manner.

People were not always enabled to be independent. We noted throughout the day that staff stacked people's mobility aids in one corner of the lounge. This meant people had to ask if they wished to move from their chair. We also saw that when people wished to walk around that unless they needed to go the toilet that staff ushered them back to their chairs. One person started to walk from the lounge into the hallway and a staff member was heard saying, "Have a sit down [name] while we (staff) finish our lunch." Although the person sat with them, staff made no real attempt to talk to them. We noted in people's care plans that there was a record of when people wished to get up in the morning. However, we heard from staff that there was an expectation that night staff got six people up before they went off duty and a staff member told us, "Everyone is up and dressed when we come on duty at 07:45." The registered manager told us, "(Night staff) choose who to get up."

The lack of person-centred care shown to people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In most cases, staff used effective communication methods with people. We observed that staff got down to people's eye level when speaking to them and used a caring and reassuring tone of voice. One person told

us, "They sit down beside you and ask 'how are you today?' and that means a lot." Another said, "Staff spend time talking to, but they don't talk at you."

People were supported by staff who showed people attention. One person was dozing in their armchair leaning forward and a staff member sat beside them gently encouraging them to straighten up into a more comfortable position. The staff member tucked the person's hair behind their ear and spoke to them in a gentle, calm tone whilst rubbing their back.

People's individuality was recognised by staff and people's cultural and religious beliefs were taken seriously by staff. The home arranged visits from local church groups. The registered manager told us that the local vicar had recently moved churches and they were currently waiting for the new vicar to start. They said some people would miss the service in the meantime. This was confirmed by one person who told us, "You get a lot from it. I really miss it." We noted from this person's daily records that they regularly watched Songs of Praise on television. A relative told us, "Staff are very sensitive and understanding (to my family member's routines) as she used to be a nurse."

People and their relatives were involved in their care. Throughout the day we observed staff asking people what they wished to do and offering them choice. One person told us they felt involved in their care. Another said they received the care from staff in the way they wished it. Relatives told us that they were made to feel welcome when they visited and that staff maintained good communication with them. A relative told us, "They have moved [name] to a smaller room (whilst the building work is going on). This was done in full consultation with her and us – we have always been involved."

People lived in an environment that was homely and staff promoted people's privacy and dignity when supporting them. We saw that people's rooms were personalised and individualised to their preferences. Where people needed support with personal care, staff provided this discreetly with doors closed. We saw staff support people to the toilet, check they were okay and then close the door and stand outside until the person was ready to return to the lounge. We only heard staff being polite and kind to people throughout our inspection. At lunchtime we heard a staff member say, "[Name] your food is here." The person thanked the staff member who responded, "You are welcome." A relative told us, "[Name] loves her room. It has a big window looking out onto the South Downs. The beauty of the home is that it is very personal; not massive."

Good

Is the service responsive?

Our findings

People told us that they knew how to raise any concerns they had. One person told us, "I feel I could go to [registered manager] with any problems and she would listen to me." This person discussed with us a current issue in relation to their bed. They told us they had spoken to the registered manager about this who was supporting them to resolve this. We spoke to the registered manager about this who explained to us the nature of the issue and what they had done to try and address it. We noted no written complaints had been received since our last inspection.

We noted several compliments had been received at the home. These included, 'The place is really nice, thank you for looking after me', 'All the staff are kind and caring' and 'I find the team headed by [registered manager] to be very meticulous when it concerns the well-being of each resident'.

People had access to activities to help prevent them feeling isolated and had the opportunity to follow their social interests. There was a variety of activities going on at the home. The timetable showed that activities included exercises, quizzes, visiting entertainers and arts and crafts. The home did not have an activity co-ordinator who planned activities. Instead it was the responsibility of staff to organise activities when these were not provided by an external provider. A staff member told us, "We usually do an activity every day. People enjoy it. It gives them a boost – makes them feel good." Where people were cared for in bed, staff spent time with them one to one. Staff kept a record of activities and these showed people had regular time engaging in activities. We read in people's daily notes they participated board games, pampering and sing-a-longs. One person spent a lot of their day reading a book and another person had spent some of their day knitting before going out with their relative. This person told us they enjoyed knitting and had orders for the knitted Father Christmas's that they were making. Staff encouraged the person to show them their progress in what they were producing.

We observed an activity taking place in the morning and people were engaged and enjoying it. People were taking part in an exercise activity. During the afternoon some people sat in the dining room and painted with staff. Others chose to remain in the lounge area and listen to music. We asked them if this was their choice and they told us it was. External provider activities included music therapy, pet therapy and opera. One person said of the activities, "It's fine, it's like we are all together." Another told us, "I spend some time in my room, but I come down here too." A staff member said, "I think there is enough for people to do. They are going to start cookery too."

People had the opportunity to access the wider community. The registered manager told us they had been keen to get people out more, particularly as due to the building work they were unable to access the garden during the summer. They said they had taken people to a local theatre, but due to the length of the show and transport arrangements they found this had left people feeling disorientated and confused. Instead they found an afternoon drive worked well for people. People enjoyed driving around the local area which they recognised, returning home in time for afternoon tea. The registered manager told us people came back relaxed and calm having enjoyed the trip out.

People's care plans reflected their needs and preferences and people received responsive care because staff knew them well. One person had a stoma bag and staff were able to describe how this was cleaned and changed. This same person had diabetes and they knew to look out for signs of this person suffering from low sugar levels. Staff tested the person's sugars each day. We read peoples histories were written in care plans so staff had a sense of the person before they moved into Wolfe House. One person had a very detailed history written by their family. A relative told us that they were very much involved in their family member's care plan. One person's care plan stated, 'Staff to ensure I have it (hearing aid) in when I wake up." We saw this person was wearing their hearing aid. This same person required a double-handled cup to drink from and we observed this had been provided to them at lunch time. People's care plans detailed people's level of independence in relation to how mobile they were, what personal care they could carry out for themselves and what day to day decisions they could make.

Requires Improvement

Is the service well-led?

Our findings

Although people received responsive care we found records in relation to people were not always contemporaneous. Where people required topical creams (medicines in a cream format) the application of these was not always signed off on their medicines records chart. We saw that although people had a separate body map to show where the cream should go, there was no record to show when staff had applied it. Information relating to this was included in the daily notes which meant it would be difficult to track. Furthermore, there was no indication on the person's body map to indicate how often the cream should be applied. We asked the registered manager about this who told us, "Staff just know." Again, although staff knew that one person should only have one daily dose of their inhaler, rather than four, we found their records did not reflect this. One person had diabetes and yet there was no diabetic care plan for them. Another had epilepsy and again there was no care plan for this.

Although the registered manager was able to demonstrate appropriate action had been taken in response to accidents and incidents and we saw information in relation to these in the accident file, the actions taken were not always recorded. Records relating to people were written in advance of them receiving care. We noted that each person's records for the day had been written by mid-morning. This included information about their continence, food/drink as well as activities. Each person's care plan was written in a similar way. This meant that the information recorded in a person's care plan may not reflect the true outline of their day. For example, we saw that one person had written in that they had taken part in painting, but in fact they had gone out with a relative. Two other people had also been recorded as taking part in the afternoon activity, but they had declined. Daily notes for people were written in a very task-orientated way, with wording such as, 'personal care given, bowels opened, ate well'.

The lack of contemporaneous records in relation to people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to regularly check and assure the quality of the care that people received. The registered manager carried out frequent audits within the home. Audits covered areas such as health and safety, food safety, infection control and training. Where improvements were identified these were actioned by staff such as one sink that was found coming away from a bedroom wall. However, we found that audits were first completed in 2014 and each year were ticked to say they had been completed. We also noted that an external medicines audit had recommended that staff medicines competency checks were recorded. We spoke with the registered manager about this who told us they did observations on staff but did not write these down.

We recommend that audits carried out on the service are robust and competency checks in relation to medicines administration are recorded in order to evidence that staff are following best practice.

People and relatives told us that they got along with the registered manager. One person told us, "I can speak to her." A relative said, "The manager is very good. When I come here the manager will always let me know what I need to know about [name]. When you want a meeting then it's arranged."

During the inspection we observed the registered manager interacting with people. People responded warmly and it was evident that they got along well with the registered manager. The registered manager worked alongside staff to meet people's needs and was very hands on.

The registered manager promoted a positive culture within the staff team and it was evident she cared for people that lived at Wolfe House. Staff told us they felt supported by the registered manager. One told us, "I feel supported. I can always talk to [registered manager]. She is a good manager. She is reliable and wants the best for everyone." Another said, "I feel supported. I feel valued mainly by the residents. They tell you how you do. [The registered manager] has a hands-on approach; you can go to her with anything." Staff were encouraged to provide feedback and suggestions on ways they could improve the running of the home. Meetings took place regularly and minutes were recorded.

The registered manager told us in turn that they felt supported by the registered providers. They said, "They visit once or twice a week. I feel supported and if there is anything I need they will get it for me. They were concerned that we may not be able to show people a nice home whilst the building work was going on and asked what they needed to do to make rooms look better in the meantime."

The registered manager was responsive to our feedback throughout the day and took immediate action where they could. For example, we found the overhead light in the bathroom was not working and that the tap in one person's room had no water coming from it. The registered manager raised this with the provider and they were being addressed by the end of our inspection. We also found that the home's CQC ratings were not displayed for people to see. This was remedied by the time we left the building.

People and their relatives were involved in the running of the home. Regular meetings took place and we noted from the minutes of the last meeting that staff had discussed the impending building works with people, planned external outings, discussed the medicines policy, complaints and menus. The provider demonstrated their wish to improve the service for people with their commitment to improving the environment as part of their refurbishment programme.

The registered manager was aware of their statutory requirements and duties in relation to CQC. Services registered with us have a duty to notify us of any safeguarding or serious accidents or incidents. We found that the registered manager had submitted appropriate notifications to us in line with their requirements.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to provide person-centred care to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to follow the legal processes in relation to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to hold contemporaneous records in relation to people.