Melton Care Limited

The Amwell

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Amwell is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service offered support to older people and people who were living with dementia or physical disabilities. At the time of our inspection there were 47 people using the service. The Amwell is a purpose built and set over four floors. There was a communal lounge and dining room on each floor. The Amwell had a gym, a cinema, a bistro and a hairdressing salon available for people to use.

This was the first inspection of The Amwell since its registration with the CQC.

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.

Quality assurance systems were in place to monitor and review the quality of the service which was provided. These had not been used effectively to drive improvement in the service and had not identified the concerns we found.

Risks to people were assessed and monitored regularly. However, the information included in the assessment was not always updated if a person's needs changed. There was no clear guidance for staff about how to support a person if they became aggressive.

Checks on the environment had not all been completed at the required frequency, however were being updated during our inspection.

People told us they had to wait for support. Staffing levels had been assessed and the registered manager told us they would continue to monitor these. Safe recruitment processes were in place.

Systems were in place to ensure the premises were kept free from infection and hygienic. These were not always followed by staff. There were processes being developed to make sure action was taken and lessons learned when things went wrong, to improve safety across the service.

Staff had not received training and support to carry out their roles. Training was available but staff had not been supported to complete this. Staff had started their employment before they had completed appropriate training.

People were supported to maintain their health and well-being, although the care given to people to show this was not consistently recorded. Where a person was at risk of not eating enough the records of what they

had eaten were not regularly completed which appeared to show people had sometimes only had one meal and limited drinks. Staff confirmed people were eating and drinking and this had not been recorded.

People's needs were assessed and their care was sometimes provided in line with up to date guidance and best practice. The premises and equipment were not fully adapted to meet people's needs

People usually felt safe when they were receiving care from staff. Staff understood their roles and responsibilities to safeguard people from the risk of harm.

People were supported to take their medicines. There were processes in place which staff followed to make sure people received their medicines safely.

Staff demonstrated a limited understanding of the Mental Capacity Act 2005. They gained people's consent before providing personal care.

People's private information was not always kept securely to maintain their confidentiality.

People felt they did not receive staff support at times they needed this. They felt they did not always get to know staff due to changes in the staff team.

People were treated with dignity and respect and staff ensured their privacy was maintained. People were sometimes encouraged to make decisions about how their care was provided.

Care plans were not focused on the person and their wishes and preferences. People and their relatives were involved in the assessment process although they felt their views were not always listened to.

People were supported to take part in activities and encouraged to participate in events within the service. There was a complaints procedure in place to enable people to raise complaints about the service.

People and relatives had been asked for their feedback of the service and had attended meetings with the provider.

This is the first time the service has been rated Requires Improvement.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. 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?

Requires Improvement

The service was not always safe.

Risks to people had been identified and assessed. These had not always been updated when a person's needs changed. The measures needed to keep people safe were not detailed.

There was no guidance for staff on how to keep people safe if they displayed aggressive behaviour.

People had to wait for support. Staffing levels had been assessed. The provider followed safe recruitment practices when employing new staff.

People were protected from abuse and harm by staff who knew their responsibilities for supporting them to keep safe.

People were supported to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not effective.

People were cared for by staff who had not received the appropriate training and support they required to carry out their roles.

People who needed their food intake recording to maintain a healthy diet were not monitored. Records were not consistently kept of what they had eaten.

People's consent was sought before staff provided care.

People were supported to access healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always feel they got to know staff well. They did not feel they were given time or support when they needed it.

People's private information was not always kept secure to maintain their confidentiality.

People were treated with dignity and respect and staff ensured their privacy was maintained.

People were encouraged to make some decisions about how their care was provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that met their needs as their needs were not recorded in detail in their care plans.

People attended activities and had access to different facilities within the service.

People had information on how to make a complaint and the provider had systems in place to deal with the complaints.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance systems were in place to monitor and review the quality of the service which was provided. These had not been used effectively to drive improvement in the service.

People had been asked for their feedback and this had been reviewed.

The provider had not always notified CQC of allegations of abuse which they are required to do.

The Amwell

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 comprehensive inspection took place on 22 February 2018 and was unannounced. The inspection was carried out by two inspectors, a specialist nursing advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information that we held about the service such as notifications, which are events which happened in the service the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider. We also sought feedback from Healthwatch Leicestershire (the consumer champion for health and social care).

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff and people's interactions throughout the day and how the staff supported people. We spoke with four people who used the service and four relatives of people using the service. We spoke with the registered manager, a quality consultant who was working with the service, the head of care, a nurse, the provider's business manager, five care staff, one agency member of staff, two housekeeping staff and the chef.

We reviewed the records and charts relating to nine people and three staff recruitment records. We looked at other information relating to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

People usually felt safe when receiving care from staff and living at The Amwell. One person told us, "I like that all the windows and doors are closed. That makes me feel safe." However, another person commented, "Sometimes I don't feel safe when they are turning me." Relatives told us they felt safe with the support their family member was receiving. One relative said, "I feel [person] is safe as they can do some things for themselves." Staff told us they had received appropriate training with regards to safeguarding people from avoidable harm and protecting people. One staff member said, "I would talk to the manager and report any concerns." Staff knew how to raise whistleblowing concerns and one commented, "I can always go to CQC or the safeguarding team." The registered manager was aware of their responsibility to report any concerns to the local authority and had done so when allegations had been made.

Risk assessments were in place to reduce the likelihood of injury or harm to people. These included people who were at risk of falling. These had been reviewed on a monthly basis to make sure they remained up to date and reflected changes to people's circumstances. However, we found that measures to reduce risks to people had not always been identified and the information was not the same in different documents. For example, one person was identified as being as a low risk for falls. There was information in the risk assessment which showed there had been a change in the person's needs which made them a high risk of falls. Despite this there were no control measures in place to protect the person from the risk of falls. Another person had a risk assessment in place as their skin could become damaged. The score for the person had been added up incorrectly which identified the risk to them as lower than it really was. The member of staff who had completed the assessment did not identify the person had a previous injury to their skin which would have increased the score and showed they were at high risk of possible problems with their skin. There were no control measures to reduce this risk. The registered manager told us they would review the risk assessments to ensure information was correct, up to date and identified where people may be at risk when receiving care.

Assessments were in place which aimed to give staff guidance on how to support people with behaviours that may challenge. This included where people were aggressive to other people. There were no clear strategies and guidance in place for staff to follow should incidents of behaviour occur. A member of staff told us staff would try to de-escalate the situation by using training called MAPA (Management of Actual or Potential Aggression); however they were not trained in this despite working regularly with people who were known to become aggressive. The registered manager told us they worked closely with an external team called the In-reach team who supported the staff with how to best manage times when people showed aggressive behaviour. They explained care plans would be updated to include guidance for staff.

People told us they sometimes had to wait for support. One person said, "Sometimes they take a long time to come when you press the buzzer and sometimes don't come at all." Another person commented, "There are not enough staff at night. There are only two. On one floor they put one person to bed and then someone else gets up." One person told us, "They always say I will be back in a minute, sometimes they leave you in the middle of something to care for someone else." Relatives also felt there were times people had to wait. A relative told us, "There is not enough staff and there is a high turnover. It can take a long time

if [person] presses the buzzer]." Staff told us they felt there were enough staff on duty. The registered manager explained they used a dependency tool to help determine how many staff were needed based on the needs of people using the service. They explained there were additional staff each day to clean, cook meals and carry out activities to support the care staff. Following our feedback the registered manager agreed to work closely with the care staff and carry out observations and feedback to see if there were times people were waiting for support and the reasons for this. They also agreed they would allocate staff tasks to try and ensure the team worked together to meet people's needs and carry out all tasks.

The length of time it took to answer call bells had been monitored monthly and if a call bell had not been answered within 5 minutes a senior member of staff would call the staff to see if there was a reason for this. The rotas confirmed the staffing levels were as described by the registered manager. Agency staff were used to ensure staffing levels were maintained. The registered manager told us wherever possible these were staff who had worked at the service previously to maintain consistency. Recruitment procedures were followed to ensure all staff were suitable to be working at the service.

People received support to take their medication. One person commented, "They give me paracetamol if I am in pain and make sure I take it." A relative told us, "One nurse left a pack of tablets with [person] and then went to see another resident. It should have been locked away. Luckily I was there to see it and report it." Medicines management systems were in place and were followed. We spoke with a member of staff who was responsible for administering medicines on the day of our inspection. They were able to explain the procedures in place and what to do if there was a medicines error which was in line with the provider's policy.

Staff who administered medicines had received training to carry this out and been assessed and deemed competent to administer medicines. People had an electronic Medication Administration Record chart (MAR) which included information about the medicines they took. These had been completed correctly and there were no errors in the MAR charts we looked at.

People's environment had been assessed. Environmental risks had been assessed and were monitored to make sure people were protected as much as possible from avoidable harm. Checks on the building and equipment in use had been completed including fire safety checks and drills. However these had not been completed for two months prior to our inspection. The registered manager explained they had not had a maintenance person since December 2017 and they were recruiting to this role. The senior maintenance worker from another of the provider's home was carrying out required checks on the day of our inspection and would be providing support to the new worker when they had been employed.

One person had an air flow mattress which is used to move air around to reduce pressure. The mattress has to be at the correct setting in order to be effective for the person. The mattress was set at a weight 34 kilograms higher than the person's weight. This meant the equipment may not have been as effective at reducing the risk to the person and was not being used in line with guidance for the mattress. Checks had not been carried out to make sure this was used correctly.

People had plans in place to guide the staff on the support they required in case of a fire. However, these did not include information such as if a person was confused which could impact on their ability to follow instructions if there was a fire or an alarm. The registered manager told us the plans would be reviewed to include this information.

People were usually protected by the prevention and control of infection. Audits were completed including the environment and water checks. These had not been done since December 2017 but were taking place

on the day of our inspection. The provider had made personal protective equipment available for staff such as aprons and gloves and these were used, although we saw staff did not always wear aprons when supporting people at meal times. Staff had completed training in infection control to improve their understanding and there was a policy in place to provide guidance for staff.

Staff understood their responsibilities to raise concerns in relation to health and safety and near misses. Incident and accident forms were reviewed by the registered manager to ensure actions had been taken. The registered manager explained they were developing practices so areas of learning from accidents and incidents were shared with the staff team.

Requires Improvement

Is the service effective?

Our findings

Staff were not always supported to develop the knowledge and skills needed to carry out their roles and responsibilities. One person said, "The staff have to use a hoist with me. Some of them are still learning how to use it." Another person commented, "I think the staff are well trained to look after me." A relative told us, "Some staff are trained, but many are not trained to meet individual needs." Staff were provided with support and training, however they told us this was not always before they started working at The Amwell. One staff member said, "I have done a basic moving and handling course and been booked onto a full moving and handling and infection control course. I don't know if I am doing any others."

Training records showed staff had access to a wide range of courses including specialist training to meet people's needs and to develop their knowledge and skills. However, there had been very few staff who had completed these courses. There were three staff who had worked at the service for nearly 12 months who had completed very limited training. One of these staff had only completed an induction which included an introduction to the service. Three staff had started work in 2018 and had only completed an induction and four staff had completed an induction and a basic life support course since starting their role in 2017. The registered manager told us they had asked staff to bring certificates from previous employment which were in date to show they had completed training and staff still needed to bring these in. They also told us an incentive had been made available to staff who completed their training by the end of February 2018. They told us new staff would be given access to the online training before they started working at the service. The staff did not receive appropriate training in order to meet people's needs.

These matters constituted a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Staff told us they received supervision. A plan had been developed to ensure all staff had regular supervision meetings during 2018. The registered manager was working with a quality consultant who had identified staff supervision needed to be developed to make it more meaningful. They had developed a new format for supervision which was focused on the staff member's performance. This was being implemented across the service to ensure staff received regular supervision including observed practice, competency checks and an annual appraisal of their work.

People's care was assessed to identify the support they required. The assessment covered people's physical, mental health and social care preferences to enable the service to meet their needs. The registered manager told us they worked closely with health and social care professionals to identify people's needs. However, a relative told us, "They don't know how to look after [person] as they don't know their needs." The assessment was used to develop a full care plan for the person. The assessment asked questions to guide the person completing it to identify what needs a person had. There were sections for additional information to be added to ensure the assessment fully considered the person's preferences and information about how to meet their needs. This had not been completed for the assessments we looked at. This meant the assessment was not detailed to offer staff guidance on how to fully meet the person's needs.

People were usually supported to maintain a healthy and balanced diet. One person commented, "I have enough to eat and drink and we have a choice." However, a relative told us, "They missed giving [person] their supper. They said it was given but two family members were there and saw it was not. They also forgot [person's] breakfast on another morning." People who were identified to be at risk of not eating and drinking enough had charts in place to record what they had eaten. This was important to make sure they were receiving enough food and drinks. These had not been completed on a regular basis by staff. Two people whose records were viewed were at a high risk of not eating enough. Both were only recorded as having eaten breakfast on one day and two meals on other days. Staff told us both people were offered food and supported to eat this, and it was a recording issue. Neither person had lost a significant amount of weight which showed they were eating and drinking and this had not been recorded correctly.

People had been involved in developing the menu and this included meals people had asked for such as spaghetti bolognaise. The cook told us, "We have changed the menu three times since we opened. We ask people at resident's meetings what they would like and try things. We used to do a hot lunch and a sandwich tea but we changed it recently as [registered manager] thought it would be a good idea." Some people told us they preferred having their main meal at lunchtime and a lighter tea. We discussed this with the registered manager and following our discussions they completed a survey with people following our visit and most people (25 out of 35) said they wanted to keep the main meal in the evening. The registered manager told us a hot choice such as soup was always an option.

People were asked each morning what they wanted for their lunch and evening meal. There was guidance for staff in relation to people's dietary needs; the cook was aware of this and provided meals for each person who needed something different such as a pureed meal to reduce the risk of them choking. There were menus in place. We did not see these displayed around the home to remind people of the food choices available.

People were supported by staff to use and access other services although people told us they could not always access a GP. One person commented, "I asked to see the GP and the nurse told me it was a waste of time because they would not come out. This was two weeks ago and I have not seen them." The registered manager told us the GP had refused to offer a home visit service and they were working with the Clinical Commissioning Group who oversee GP's to try and resolve this. They explained GP's were called when people needed to see them. Input from other services and professionals' such as district nurses, physiotherapists and dieticians was not always documented clearly in people's files. Health records had not always been updated to show the outcome of appointments or to show things had been followed up such as medicine reviews. The registered manager told us staff were being trained in how to use the system correctly to try and improve the record keeping and hand held devices were to be introduced so staff could record what someone had eaten as soon as this had happened.

People's diverse needs were not always met by the adaptation, design and decoration of premises although the registered manager was planning to make changes to the environment to make it more suitable for people's needs. For example, where people were living with dementia their bedroom door had been painted in a bright colour of their choosing to make it resemble a front door. This is in line with good practice guidance for supporting people who are living with dementia. The registered manager told us they had a one year plan to develop a retro sensory lounge with reminiscence items to prompt people to spend time thinking about their past and also had arranged for staff to attend dementia training to develop their knowledge. However, other good practice guidance such as using different coloured plates, table cloths and cutlery to improve the dining experience for people who were living with dementia were not implemented. The service had nice décor that promoted 'restaurant style dining rooms', however, these did not take into account people's needs for adaptations.

During lunchtime we noticed there was limited space in the dining room. One person wanted to leave the room and was supported to do so; however several people had to move from their seats so there was a pathway for the person to leave the room and then move again when they came back. The dining room did not have enough space for the number of people in the service or for people who needed room to move if they were using equipment such as a frame.

People moved around between the rooms and had access to a cinema, hairdressing salon, bistro and gym. They choose where they had their lunch and who they sat with although generally stayed on the floor of the home they were living on. There was a private dining area which could be used for special events or for families to eat together. People had been involved in choosing their own room and had their own belongings to make this homely.

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had requested DoLS authorisations where these were needed. They understood their role in assessing people's capacity to make decisions and had completed assessments for people in some specific areas to determine if they had capacity. However, the assessments had not always been completed. For example, one person was believed to not have capacity about the decision for a floor sensor to be used to keep them safe and reduce the risk of falls. There was no consideration of their ability to consent to taking their medicines even though the care plan identified they would not be able to understand why they took the medicines and would not be able to consent to this. The person was diagnosed with a severe cognitive impairment which could impact on their ability to make decisions. A member of staff told us, "[Person] cannot make any decisions." Their care plan did not detail what had been done to support the person to make their own choices about any area of their life such as what to wear or what to eat. A member of staff said, "The family bring clothes in. If [person] doesn't want to eat something they won't." The staff did not show understanding of how to involve people in making their own decisions where they could do so.

Staff training was available on the MCA and some staff had completed this. Staff were observed to ask people's consent before supporting them. They respected the person's choice if they said they did not want to do something at the time they were asked.

Requires Improvement

Is the service caring?

Our findings

People told us they did not always get to know staff who provided their care. One person said, "You don't get to know the staff as they don't last very long." A relative told us, "I find it hard to build a rapport with staff as new faces appear often. I don't know who does what." However, other people told us they did get to know staff well. A relative commented, "The staff understand [person] and what they like and dislike."

People told us staff were kind and one person said, "The staff are kind and considerate." During our visit staff spent usually time talking with people and reassuring them if they were unsure about anything. A member of staff told us they were new to the service. They said, "I am getting to know people and asking about themselves and talking to them." They spoke in a respectful tone and did not rush their speech, giving people time to respond.

People's life history and wishes were considered as part of their care however, the information which was recorded was not detailed to enable staff to use the information to have meaningful conversations with people. A relative told us, "Information about the individual does not seem to be passed on to staff."

People and their relatives told us they did not always feel like they were given support and time when they needed this. One person said, "I needed support to rub deep heat in. The staff said they would come to assist and they never came back." A relative commented, "When I visit, I do not see staff paying much attention to residents. They don't sit and talk to them." During lunchtime one person was struggling to eat their sandwich and was trying to use a spoon for this. They asked staff what the food was. The staff answered it was a sausage roll and walked away. They did not spend time with the person to offer them assistance.

People's individuality was sometimes respected and staff responded to people by their chosen name. In our conversations with staff, it was clear some staff knew people well and understood their individual needs. However, other staff were not able to provide information about people and their needs. We discussed this with the registered manager. They told us they were trying to recruit staff to work on a specific floor so they had the time to get to know people well and to provide consistency in staffing.

Staff understood the importance of promoting equality and diversity, respecting people's religious beliefs, their personal preferences and choices. People were usually involved in making decisions about how they wanted their care and support provided. Staff were observed to offer people a choice if they changed their mind about the food at meal times and were offered a choice of meals each day. However, one person commented, "They never asked me if I wanted a bath. I am happy with a shower." This showed people were not routinely being offered choices about their care. The registered manager explained how they promoted people's personal preferences, for example, a married couple had a shared room and a separate room which was treated as a lounge in order to allow them to continue living together as a couple.

Staff spoke politely to people and protected people's dignity; staff knocked on bedroom doors before entering and checked with people whether they were happy for them to enter. One person told us, "The staff

speak to me when caring for me. They treat me with respect and dignity."

People's care records and personal information were usually kept securely and the provider had a confidentiality policy. Documents were kept in locked cabinets or on a password protected computer. However, a member of staff was showing us the care plans and left the room unattended and the computer unlocked for a short space of time when we left the room. We also found information left on display about an individual on a computer in the activities office.

If people were unable to make decisions for themselves and had no relatives to support them, the provider had ensured that an advocate would be sought to support them. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Throughout the day of the inspection we observed family and friends welcomed as they visited their loved one. One relative said, "They do say make yourself at home, and we do feel welcome." There was an area on each of the floors where visitors could make themselves a drink and speak in private if they did not wish to stay in their rooms.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to admission so a care plan could be developed to provide staff guidance on how to meet their needs. As part of the admission process, people and their relatives were involved however, they told us their views were not always recorded. A relative commented, "I saw [person's] care plan 10 days after they were admitted. They asked me if I agreed with it. I don't agree with all of it and it hasn't been revisited."

Care plans were not focused on the person and included limited information about their preferences, communication and support needs. Information was not consistent and did not give staff guidance on the person and how to meet their needs. A relative told us, "I asked to see the care plan of [person]. There were serious errors about mobility and sight. It referred to [person] as being of the opposite sex. It seemed to be pasted from other plans. It had to be re-written." Another relative commented, "They don't know how to look after [person] as they don't seem to know their needs." Care plans we looked at referred to people as being of the opposite sex. Information was contradictory such as one person's care plan said they were a low risk of falls in one area of their plan; in another it said they were at high risk.

There was limited guidance on how staff should support a person with their diabetes. One person was recorded as needing insulin. There was no guidance for staff about this in the medicines care plan, and it was referred to in the care plan about nutrition. There was no details of who should administer this and any possible complications the person may have as a result of having diabetes, such as staff needing to be aware of the possibility of problems with eyes and feet. The plans were reviewed regularly and updated when a person's needs had changed.

Staff told us they could not access the care plans as these were only available electronically, so had to learn about people's needs from other staff. One staff member commented, "I have no login for the computer so cannot access the care plans to read them or make entries." Another member of staff confirmed this. They told us, "I have no login so cannot access the care plans or update the care records. I have got to know people by talking to the other staff." We discussed this with the registered manager. They told us they were implementing a new care planning system which staff would have training on and all care plans would be rewritten with a plan of three care plans being rewritten each week.

People and their relatives had not always been asked about their wishes at the end of their life. If the person and their relatives had made their wishes known these were recorded in their care plan. This took into account wishes and preferences and was focussed on the person having a dignified death in line with their wishes. The registered manager told us they had identified staff needed to receive training on how to support people at the end of their life and were going to enrol staff on a course about end of life care.

People were encouraged to take part in activities both as part of a group or individually. There were activities planned such as a singer coming in, an afternoon tea party for Mother's day and a party to celebrate one year since the service opened. A relative commented, "I think they need some activities which stimulate people. They have puzzles and skittles which a lot of people cannot take part in." Another relative

said, "I don't think there are enough activities for [person] with their diminishing sight and hearing. The activities co-ordinator is always busy helping with breakfasts or on the desk."

There were different activities available around the service. These included a gym which people could use for their leisure or for rehabilitation. The registered manager told us this was not used regularly and they were considering a different use for the room. There was a cinema where people could watch films with family members or sports events such as the Rugby World Cup. There was also a salon where hairdressers and barbers were available three days a week. This included a nail bar so people could have their nails painted. There was also a bistro where people and their families could have a coffee and cake and spend time together. The registered manager told us the chairs in the bistro were not supportive and would be changed to make it more suitable for people to use comfortably.

The service provided an Amwell Gazette which was a newsletter which looked back at the activities people had participated in over the last three months. This included pictures of people baking, doing armchair exercises, visiting a 'Victory Show', going on trips to a park, having a visiting pet, fundraising for charity through a coffee morning and visits from a local nursery. This showed people had access to a variety of activities throughout the day.

People's spiritual needs were met. A local faith minister visited regularly and people were supported to practice their religious beliefs.

The provider looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information was available in different formats such as large print to make it easier for people to understand.

People and their relatives were encouraged to raise any concerns or complaints. One person said, "I would know how to complain and would raise one if I had to." Another person commented, "I have had concerns addressed so there was no need to complain." There was a clear complaints policy and procedure in place, complaints received had been dealt with appropriately and were logged and monitored. Actions were put in place to avoid the issues happening again.

Requires Improvement

Is the service well-led?

Our findings

The quality of care was regularly monitored by the registered manager and an external quality consultant had been brought in to support the provider at all of their services. Audits were carried out on areas the environment, medicines, and health and safety. An action plan had been put in place to address concerns which had been identified through these. However, the action plan was very limited, it did not include information about what would be done to make the improvements and did not include all the concerns we found. The registered manager sent a much more detailed action plan following our inspection to address all of the concerns we identified.

The care planning system had an alert function which would identify if a task was not completed. There were 147 actions which had not been completed dating back to 17th February 2018. These included completion of care records such as food and fluid charts to ensure people were receiving enough to eat and drink and records to show people had received all of the care they needed. The alerts had not been followed up and the actions had not been completed. There were also a number of alerts which were not in place to remind staff of important actions. For example, one person was at risk of not eating enough. They needed to have their food intake recorded to show how much food they were being given. The alerts to remind staff to complete this chart were not in place so staff were not made aware of the chart not being completed. This resulted in care records appearing to show people were not receiving the care they needed. Staff were confident the care had been given including people having their meals. The system was not being used effectively to identify where care records had not been completed and then action taken to address this.

The care planning system was also not used correctly which meant care plans were not based on individual needs and were not completed correctly. The audits in place had not identified the information in the care plans was limited, not reflective of the person and contradictory. This meant information was not accurate and properly analysed to ensure staff had the guidance they needed to meet people's needs.

These matters constituted a breach of Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to submit statutory notifications in relation to incidents that they have a duty to report to CQC by law. For example, allegations of abuse. The provider did not notify us of three incidents of suspected abuse although they had informed the local authority of the allegations. These notifications are an important safeguard for people using the service. Failure to notify CQC denies people an important level of oversight and protection.

These matters constituted a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents.

The service had a registered manager and they were supported by a head of care, a clinical lead and an external quality consultant. We received mixed feedback about how the service was managed. One person told us, "I don't think the service is particularly well-led." Another person commented, "I have no confidence

in the management that my request to change rooms will go through." A relative told us, "I know who the manager is and she is approachable."

The service had an open culture where people and their relatives had opportunities to share information and be involved in the running of the service. Relatives told us, "There is a relative's meeting at the weekend. I will be attending as I have some concerns." Feedback had been sought from relatives through a quality survey which had been sent out in the last week. The registered manager told us they would review the responses once they were received. People were also asked for their views. Reviews had been carried out with people to ask their opinion on staff training, their care plan, if they liked their room and the activities. Feedback from these had been positive. Following our inspection people were asked when they would prefer their meal times. The registered manager also told us they would carry out satisfaction surveys for people on a regular basis to review their experience of the quality of care they received.

There were procedures which were being developed to support the staff to provide care and support. Staff demonstrated their knowledge and understanding around such things as whistleblowing, and safeguarding. The supervision process was being updated to be more focussed on staff coaching and performance. This had been identified as an area for improvement by the provider and support had been brought in to address this. Supervisions were being planned for 2018 to ensure staff had regular contact with a manager and review of their performance.

Staff attended team meetings. The minutes of these confirmed that staff had the opportunity to raise concerns, share ideas around good practice and learn together from any outcomes to safeguarding investigations or complaints.

The service worked in partnership with other agencies in an open honest and transparent way. Working in partnership with other agencies who commissioned services and local authority safeguarding and community health teams ensured that people received a joined up approach to their care and support. The registered manager was working with the local authority to improve the quality of the service. The feedback from the local authority at their visits showed the registered manager had engaged in the process and was working to put in place the processes they were asked to.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents 18 (1) (2) (e) The provider had not notified CQC of three allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) (2) (a) (b) The provider did not use the systems in place to identify where quality and safety were being compromised and did not respond without delay. The information was not accurate and had not been analysed to ensure appropriate action was taken. The provider did not use the system to identify and assess risks to the health and safety of people who use the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) (2) (a) The provider did not have suitably qualified and competent staff to make sure they could meet people's needs.

The provider did not support staff to undertake training, learning and development to enable them to fulfil their role.