Four Seasons Health Care (England) Limited

Melton House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 15 and 20 March 2017 and was unannounced.

Melton House Care Home provides accommodation and support for a maximum of 32 people. There may be people supported who are under 65 but the majority of people using the service are older people, some of whom may be living with dementia. People using the service may also have a physical disability. Accommodation is spread over two floors and there is a lift for people to move between floors. At the time of our inspection, there were 28 people 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. The registered manager completed their registration with us in June 2016.

At this inspection, there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some risks to people's safety, which had not been robustly identified and addressed. This included concerns about fire doors, a risk of burns from a hot water pipe and inconsistent staff knowledge about moving and handling practices. These issues potentially placed people at risk while they were receiving care.

There were enough staff to meet people's needs safely but recruitment processes were not sufficiently robust. They did not gather all the information required to determine, as far as practicable, whether staff appointed were suitable for their roles.

There was a wide range of audit tools and checking systems being used but they were not fully effective in identifying where the service needed to improve. The provider's oversight of the systems applied within the service was also not robust and supportive of the registered manager. This compromised the consistency and effectiveness of leadership at the home.

You can see the action we told the provider to take at the back of the full version of the report.

Where staff took responsibility for administering medicines, the process was largely safe although there was some inconsistent practice in ensuring people took their medicines promptly.

Staff were trained to recognise concerns that people may be at risk of harm or abuse and were clear about their obligations to report any such concerns so that people could be properly protected. Staff understood how to manage individual risks to people, for example to their skin integrity, from falls and while eating or

drinking and received relevant training. The registered manager monitored the completion of training and supported staff to discuss their performance, understanding and training or development needs.

People had a choice of food and drink and enough to eat and drink to ensure their wellbeing. They were also supported to access health professionals for advice about their health and welfare so the service supported them effectively to recover when they were unwell. Staff supported people with some significant health needs and understood when they needed additional advice and guidance. Where people were not able to make specific, informed decisions about their health or wellbeing, staff took their best interests into account.

Although there were isolated lapses in the professionalism of staff, they supported people in a way that promoted their privacy and dignity. They showed concern for people's wellbeing and offered encouragement, support and reassurance when it was needed. People valued their approach and the kindness that staff showed.

People's needs were assessed and staff kept people's information up to date. They understood people's backgrounds and interests so that they could engage with people about the things that were important to them. However, people's individual preferences for their personal care were not always met. The way records were kept sometimes compromised how staff could show the support people received matched their needs and preferences. Small attention to detail, such as ensuring clocks worked and were accurate, had the potential to compromise people's ability to orientate themselves to time and day.

The registered manager operated an effective system for receiving and responding to complaints and dealt with these robustly and sensitively to resolve issues. People received a response to their concerns, an explanation of events and the arrangements for ensuring improvements were made in response to complaints. People and their visitors were confident in the way the system worked. They were also encouraged to express their views about the service in surveys, at meetings and through the provider's electronic system.

People and their visitors valued the approachability of the registered manager and his 'open door' approach. Their comments showed a good level of satisfaction with the quality of the service they received.

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.

There were risks to people's safety associated with the environment in which they lived and inconsistent staff knowledge about the use of equipment to assist people with their mobility.

There were enough staff to support people safely but recruitment processes and checks were not consistently applied.

People generally received their medicines in a safe way, but staff accepting responsibility for giving them, did not always ensure people took them promptly.

Staff understood the importance of reporting any concerns or suspicions that people were at risk of harm or abuse.

Is the service effective?

Good

The service was effective.

Staff received regular training and support to equip them with the knowledge required to support people properly.

People were supported to make decisions about their care. Where they were not able to do so or to understand risks associated with their safety, their best interests were taken into account.

People had a choice of enough to eat and drink to meet their needs.

People were able to see health professionals when they needed to.

Is the service caring?

Good

The service was caring.

While there were occasional lapses in the professionalism of staff, they respected people's privacy and dignity when they were

offering support.

Staff offered reassurance and comfort to people when they were anxious.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that met their individual needs and preferences.

People were confident that the registered manager took their complaints seriously and made improvements in response to their concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems for monitoring the service and assessing where improvements could be made, were not working as well as they should.

Staff spoken with understood their roles and were positive about morale, although the management team were aware of some concerns for consistency and team work.

People using the service and their visitors valued the manager's open approach and were confident they could express their views about the quality of the service.

Melton 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 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.

The inspection took place on 15 and 20 March 2017 and was unannounced. The inspection was completed by two inspectors 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.

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. The registered manager completed this and returned it when they needed to. We reviewed the content of this. We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or registered manager must tell us about by law. We received feedback from staff in the local authority's safeguarding and quality assurance teams.

During our inspection visits, we observed how staff supported and interacted with people. We spoke with seven people who used the service and three of their visiting relatives. We spoke with the registered manager, deputy manager and three members of the care team. We also spoke with the activities organiser, cook and a visiting health professional.

We reviewed records associated with the recruitment of three members of staff, training records for the staff team and assessments and care records for four people. We reviewed arrangements for managing medicines, looked around the home and checked a sample of records to do with the quality and safety of the service people received.

Requires Improvement

Is the service safe?

Our findings

We found some concerns for the way risks to people's safety, particularly within the environment, were identified, managed and minimised. This included risks associated with the containment of a fire should one break out.

Nine fire doors in the corridors were shown as checked for effective closure and to ensure there were no gaps around seals and the frames. The check established whether they would function appropriately in containing a fire or needed adjustment. There were weekly checks to make sure that automatic door closing devices on bedroom doors would activate when the fire alarm sounded. However, we found that three bedroom doors did not close properly and so did not offer the required protection for people in the event of a fire. The registered manager arranged for these doors to be checked and two adjusted after our first inspection visit but we were concerned that this risk was not addressed until we pointed it out.

The provider's guidance about fire safety said that each 'break glass' point, used to sound the alarm in the event of fire, was to be tested at least once every three months. The test records showed that this was not consistently applied. We found that one alarm point had not been tested for just over three months, where another point had been tested five times in the same period. There was nothing in the fire log book to indicate 'in house' testing of emergency lights each month, in accordance with the provider's guidance.

In one upstairs toilet, there was an exposed hot water pipe in the corner of the room. We found this to be very hot presenting a risk of burns should anyone fall next to it. The Monthly Department Workplace Inspection report or the home environment checklist we reviewed did not identify this risk.

We received a concern before our inspection, that some staff were not following safe moving and handling practices resulting in some people sustaining skin tears. We saw that the registered manager had emphasised the need for staff to take care when they supported people to move, following a visit from the local authority's safeguarding and quality assurance teams.

However, there were inconsistencies in the information staff gave us. One member of the care team told us that it was the provider's policy not to use 'stand-aids' to assist people with mobility. Another staff member told us they had tried to use a 'stand-aid' for a person to assist them. The registered manager subsequently informed us there was no stand-aid in the building but the provider would supply one, together with relevant training, if someone needed it. This confusion presented concerns that not all staff were clear about the specific equipment they should use and had available to assist each person safely.

These issues, together with concerns that the provider's systems did not recognise and address them, presented risks that people would not receive safe care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had guidance about how to mitigate specific risks to people's health and wellbeing. Assessments included risks associated with pressure area care, not eating and drinking enough, falls and choking. We

found that assessments were reviewed regularly to ensure they continued to reflect individual risks properly.

We could see that staff took action to reduce risks, for example ensuring they assisted people at risk of pressure ulcers to reposition regularly. Records we reviewed showed that people were to be assisted to move every two hours. We found a significant delay for only one person, where timed records showed they had not been supported to change position for a period of over six hours. However, their skin was intact and staff understood what to look that might indicate developing concerns. They knew the importance of reporting this. One person told us how they received assistance to change position regularly.

Staff gave us consistent information about how they supported people in a way that reduced their risk of choking. This included how they positioned people when they assisted them to eat or drink, and how much thickener each person who needed it, had in their drinks.

The service completed enhanced checks on the backgrounds of prospective staff with the disclosure and barring service (DBS). This helped to ensure that staff appointed were not legally prohibited from working in care services. However, other recruitment measures were not robust. They did not show all so all practicable measures were taken to protect people by obtaining the information the law requires.

The registered manager and administrator explained to us that one the staff member appointed had taken their application form home by mistake and then lost it. The registered manager had not yet obtained a completed version for the staff member's record. They could not demonstrate a full employment history for the staff member and that gaps in their record were explored. We noted that the date the staff member's records showed they started work was before either of their references were obtained.

For a second staff member, their application form contained reference to previous employment in two different care services. There was no indication of the dates of this employment to enable the registered manager to explore gaps in their work history. The application form did not provide details of relevant references to establish the staff member's conduct in those caring posts. There were two references on file but neither was from the staff member's previous posts in care and both were personal rather than professional references.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt there were enough staff to ensure their safety. The majority of people said they used the call system and usually they did not have to wait very long. We saw that staff responded promptly to calls for assistance. One person told us, "They usually come quite quickly. If they're busy with someone else, they normally let me know if there's going to be a wait." However, two relatives had noticed that staff did not always answer call bells promptly. One said, "Last week they [staff] took over nine minutes to respond, we only wanted a cup of tea but they didn't know that." Another visitor commented to us, "Generally they're good but sometimes they're very busy. I think there's always room for one more, but that's true of most places."

We noted that the registered manager had raised concerns with the staff team about one call bell response delayed for ten minutes. They had monitored this and ensured staff were clear about expectations and arrangements for breaks.

A visiting health professional told us that there were always staff around to answer their questions and assist them with their patients. The registered manager was able to show us that they assessed people's

dependency so they could determine whether additional staffing were needed to deliver safe care. They were recruiting for bank staff to help cover for any gaps arising because of illness or holiday. Staff told us that they felt staffing levels were normally fine, unless there was last minute sickness but even then were not unsafe. Both the registered manager and deputy manager covered shifts in an emergency.

Before our inspection, we received concerns about medicines management and that sometimes there were tablets found on the floor or down the side of people's chairs. At inspection, we found that systems for managing medicines were largely safe but needed improvement for consistency. Staff assuming responsibility for ensuring people had taken their medicines did not always remain fully accountable. They told us about the checks they would make and were aware of the importance of ensuring that people had taken their medicines. However, this did not consistently happen.

Staff signed administration records to show people had taken their medicines. However, staff did not always see that people had actually swallowed their medicines in a timely way when they gave them to some people. For example, one person told us, "They tip my pills out on the table for me to take. They leave them for me because they know they can trust me to take them. Some of them are quite small and fiddly but I can manage." A health professional told us that they had once seen that staff needed to remind a person to take medicines as these remained on their bedroom table. There was a potential risk from this practice that people with medicines due more than once a day, may take doses too close together. There was also a risk of them being dropped and lost so that people affected by this practice may not receive the treatment they needed. We raised this with the registered manager so that they could ensure practice was more consistent.

Staff locked medicines away when they were not in use. However, the treatment room was accessible to all staff because they needed access to people's records or to equipment. The keys for medicines were in an unlocked wall cabinet. This meant that unauthorised staff could potentially access medicines, including controlled drugs. The latter require additional precautions in their storage and use. We ensured that the staff member responsible for medicines administration took possession of these keys. However, we were not able to check that compliance was maintained.

People told us that staff supported them with their medicines and they were satisfied with the arrangements. One person said they had a lot of medicines they needed to take four times each day. They said, "They [staff] have never forgotten to give me my pills when I need them." They weren't on to tell us, "If I have pain they will give me extra but they call the medical centre first to check it's okay for me to take them." Another person told me, "I get my pills in a pot and they watch me take them."

People felt safe in the home. For example, one person told us, "I feel very safe, I have to rely on the staff for everything and I know I can." A relative commented to us that their family member, "…calls this place home. I think that's a good sign." A visiting health professional told us that they did not have concerns about the way staff treated people when they attended to visit their patients.

Training records showed that staff completed training to help them understand their role in protecting people from harm or abuse. This included the care team, ancillary staff, such as the maintenance person, catering and cleaning staff. All of the staff spoken with understood this training and their obligations to report any concerns. They were confident that the management team would address any issues they had and were aware of the importance of blowing the whistle on poor care practices. They told us that they could go to social services or to the Care Quality Commission if they were not able to raise concerns within the home for any reason.

Good

Is the service effective?

Our findings

Staff were trained and competent to deliver care that met people's needs. People felt that staff knew how to deliver their care properly. For example, one person "They have to use a hoist for me. It always takes two members of staff and they check it's not hurting me. If it is, which sometimes happens, they lower me down and adjust the hoist then try again, they are good." A visitor made a comment in an on-line review of the home saying that their family member had been at the home for over two years and, "I am very happy with the care [person] receives. I visit nearly every day and always find [person] clean and comfortable."

Staff said they had received enough training to meet people's needs and that extra training was available if they needed it. The registered manager monitored the training staff completed so that they could follow up any gaps in staff knowledge. Staff told us that they felt well supported by the management team who they said were available to both assist and advise. They confirmed they received supervision. Supervision is needed so that staff have the opportunity to discuss their performance and development needs. They told us that this included one-to-one meetings and spot checks on their competence. The registered manager confirmed that these took place as described by staff.

The registered manager had introduced daily 'flash' meetings for the staff team. These were short meetings taking place in the middle of the morning. We observed that staff discussed people's needs, any changes or problems and identified anything they needed to follow up later in the day. This contributed to ensuring people received consistent care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

People told us that they were asked for their consent before staff assisted them with their care. We heard staff asking people if they needed any assistance, for example with their meals and where they would like to spend their time. Assessments took into account people's best interests and how staff were to promote these.

Staff were clear that they would respect people's decisions and approach them in a different way or at a different time to seek their consent. We noted from the 'flash' meeting that staff discussed one person's refusal of assistance to shower. They agreed to try to gain the person's consent later in the day. Staff were

able to explain how they supported people to make decisions and choices. They were aware that, if a person lacked capacity to make informed decisions about their care, they needed to consider what was essential and in people's best interests.

People's care records showed that they were asked for their permission to share the content of those records with other professionals when required. We discussed with the registered manager that one person's name appeared on the home's website. The registered manager said they would check whether the person still had the capacity to make the decision about publicising their comment and name.

The registered manager had made applications for authorisations to deprive people of their liberty. We discussed with the registered manager that there was an oversight in one such application. This did not include sufficient detail to indicate why the registered manager considered the authorisation was needed. Others did contain more detail, for example, where people were unable to leave the home, as they did not understand risks to their safety. The registered manager was waiting for the outcomes of these.

People had a choice of enough to eat and drink to meet their needs and ensure their wellbeing. There was information for catering staff about people's specific needs displayed in the kitchen. However, on our first inspection visit, this information was incomplete and unclear. When we returned to the service, this information had been updated and reflected more detail about people's needs. It included information about whether they needed to gain or lose weight, had diabetes or allergies, and whether a person needed a soft mashed diet or puree.

On the first day of our inspection, the menus available to people did not match what was on offer. This was roast beef rather than roast pork. However, staff did explain to people what they could choose. On the second day of our inspection, the menu displayed in the dining room and hall was consistent with menus people had in their rooms. We saw, during the morning, that staff asked people what they would like for their lunchtime meal. At lunchtime, we noted that staff offered people a choice of drinks. This included a glass of wine or a cream liqueur where this was not contra-indicated by medicines they were taking.

Staff monitored people's weights to check for any unintended weight gain or loss. However, we noted that some calculations used for their 'body mass index' were inaccurate. The registered manager corrected these between our two inspection visits so the information was clearer in determining risks associated with people's nutrition.

Everyone we spoke with was satisfied with the food and drink on offer. For example, one person told us, "The food is very good, I get enough to eat and usually there's a choice. If I want something during the day, they'll get me some fruit." We saw that fruit was freely available to people in the lounge so they could help themselves. A visitor told us how their family member had been reluctant to eat well but that staff had provided encouragement and support so their eating had improved.

People's relatives had also made positive comments about food and drink in reviews they publicised on the internet. For example, one recent review said, "Food and drinks are excellent, all homemade and wholesome." Another commented about respite care for their family member and said, "Meals were very good and varied and mum needed to have hers cut up which they did, nothing was too much."

Staff said they shared details about people's food and drink intake in staff handovers. They told us they would encourage people further if they intake was concerning. They also said they offered people snacks and this showed in their records. Staff said people of low weight had fortified food and drinks and that they offered people extra meals during the day. We saw that people's records confirmed this.

People were supported to access advice from health professionals. The dentist and doctor visited the home to see some people during our inspection. One person explained how staff had supported them to recover the health of their skin. A visitor also commented about health care. They told us their family member, "… had a leg ulcer and the care home liaised with the GP and it has healed. I'm quite impressed with that."

A visiting health professional told us that they felt the staff team were successful in supporting people with some quite complex healthcare needs. They tried to avoid hospital admissions which were unnecessary and when people expressed their wish to remain in the home. The health professional told us that they felt staff contacted the 'out of hours' service only when it was necessary and had improved the way they made such referral.

Staff were able to tell us about different healthcare professionals they would contact and when they would seek advice including the doctor and district nurse. We could see from care records that people had access to advice from dieticians, speech and language therapists and the falls prevention team where appropriate.

Good

Is the service caring?

Our findings

We observed occasions when staff did not wholly uphold people's dignity in their interactions with one another and in front of people using the service. However, in practice we saw that, when they engaged directly with people, they were polite and respectful in their manner.

We observed that a staff member was anxious to encourage a person to eat. They explained that the person might become ill if they did not eat a bit more. We saw that they did not want to withdraw their support too soon if they could persuade the person to continue with their meal. However, in doing this, they did not always support the person at their own pace and held the spoon in front of the person's mouth while encouraging them to eat some more. A colleague also interrupted the staff member while they were supporting the person. Their colleague was anxious about taking their break at 12.30, asking when they were going to get it, and why they could not have it then. This was in front of people using the service and an inspector, presenting as not as professional as it should be.

This was inconsistent with our other observations and the views of people using and visiting the service. A relative told us, "I think the staff treat [person] very well. If person needs changing when we are visiting we go out of the room and they shut the door until they have finished." A person using the service also commented about their privacy and said, "I think staff are very good in that way." Their relative agreed that this was the case. We saw that staff supported people in a way that took into account their privacy. They assisted people with their personal care in private. We noted that staff hand over meetings and the morning 'flash' meeting, took place in private so that staff discussions did not compromise confidentiality.

Staff had developed positive and caring relationships with people who used the service. One person told us, "I can't fault them [staff]. Up to now they have been very friendly." Another person said, "I've been made to feel welcome here by everyone, from top to bottom, by the manager right down to the cleaner." A relative described staff as being, "…always friendly and helpful and do their best to deal with [person's] needs." Another commented that, "I think they are very caring to my [family member]. It isn't just the carers. The cleaners and the laundry lady find time to have a little chat."

Some visitors had completed reviews about the service, which were publicly available on the internet. Two recent reviews were positive about the caring nature of staff. For example, one relative wrote that, "Staff are very welcoming and friendly; nothing is too much trouble for them." Another described the experience of their family member in receiving respite care. They wrote, "This is the third time mum has been in Melton for respite care. She loves being there and all the staff are so kind and helpful. They all remembered mum's name and asked how she was. She isn't very mobile so one of the staff pushed her down for her meals in a wheelchair. Everyone was so kind to her and she would happily return."

Care records contained references to people's life histories. Staff told us that this helped to develop relationships with people and to communicate about the things that mattered to them. We saw that staff treated people warmly and compassionately. They got down to people's eye level when talking with them and used touch effectively to calm people when they became anxious. We noted that one person became

anxious during their lunch, repeating that they wanted help. Staff intervened to support and distract them. We heard staff explaining to one person what they were doing when they used the hoist to assist them with their mobility. They checked that the person was comfortable and offered reassurance.

Some people had signed their records to show their agreement with the way their needs were assessed and planned for. Relatives were able to be involved. One relative told us, "They don't volunteer information but if you ask, they are happy to discuss care." Another relative said, "They've involved me in [person's] care. I can see the care plan and do check it."

We saw and heard staff offering people choices, for example whether they wanted to stay in lounge, go to their room or join an activity. They also ensured people were comfortable, making regular checks on people's welfare and offering one person a blanket.

People were able to have visits from friends and family when they wished. One relative told us that they visited almost every day. A person living in the home said, "My brother comes to see me in the evenings, but he could come whenever he likes."

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed and staff had guidance about how they were expected to meet them. We noted that people's assessments and care records were reviewed regularly to ensure they continued to reflect people's current support needs. Staff said they were kept up to date about any changes at hand overs between shifts and during the morning 'flash' meetings. However, the service was not always as responsive as it could be to specific needs and preferences.

We noted that not all staff were aware about specific arrangements for a person who some felt was receiving "end of life care." Other staff did not know whether this was the case or not. This presented a risk that there would be inconsistencies in the quality and nature of care the person received.

Staff felt they could respond to people's needs and preferences unless there were unforeseen staff shortages such as sickness at short notice. However, we received some conflicting views from people about whether their care met with their preferences.

Three of the people we spoke with told us that they were able to get up or go to bed when they wanted as they did not need support with their mobility. Two other people said they needed staff to help them but they were happy with the arrangements for meeting their needs. For example, one said, "It takes two carers to get me up and I know it's a busy time so I don't mind waiting." One person told us that their preferences for times of retiring to bed and getting up in the morning were not always met. They said this meant they spent longer in bed than they would like.

We noted that a clock on the table in a quiet sitting area was not working and conflicted with another clock on the wall. This meant that people, particularly those living with dementia, may not always be able to orientate themselves easily to the time of day

One person told us they liked to be able to shower. Their care records confirmed this as their preference but staff told us they were not able to get the person into the shower and washed them in bed. This was not in line with the person's wishes but the registered manager explained this was because the previous shower chair was condemned for reasons of infection control. After our inspection visits, the registered manager confirmed that they had obtained a suitable shower chair so staff could now support the person as they preferred.

Another person told us that they liked to have baths but that these did not happen very often. Their bathing records supported their assertion, showing they had only been assisted once in each of the three months leading up to our inspection. We raised this with the registered manager. The registered manager confirmed that the person had received regular support with baths but some entries were in the staff communications book rather than in the person's individual record. The registered manager undertook to address this with staff so it would be easier to monitor and to determine the person received the support they wanted.

There was an activities coordinator in post, working in the home part time, on five days each week. They told

us how they organised quizzes, singing, puzzles, reading, colouring, trips to film shows and afternoon tea at a local ex-servicemen's club, and manicures. They said they were thinking about encouraging people who were interested, with some gardening activities.

One person told us, "I enjoy the activities, sometimes we can do a little bit of cooking which I really enjoy." Another person said, "I have my television and I like to read, I don't want to participate in the organised activities but they still ask me if I want to sometimes." A relative commented to us that their family member did like to join in with religious services when these happened.

One person told us about their interests and past hobbies. This was reflected in what we saw in the person's room where they had both models and magazines about their interest. Staff knew about this and incorporated the person's interests into their conversations. Staff said that they had time to spend with people, usually in the afternoon, to engage them in either activities or just conversation. We saw that staff did spend time talking with people during the afternoon of our first inspection visit.

People knew who the registered manager was and told us they would speak to him if they had any concerns or complaints, but could also speak to staff. They felt that improvements would be made if they were needed. For example, one person said, "I'd speak to one of the carers if I wasn't sure, I'm sure they'd help me." Visitors were also confident in raising a complaint. Two visitors told us how they had raised concerns and that standards of care for their family members had improved as a result.

We noted that the registered manager had responded sensitively to a complaint about care and record keeping practices. They had written to the person making the complaint, telling them about their findings. The letter showed they had apologised for what happened and explained what they were doing to help ensure the problem did not arise again.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider's systems for monitoring the service were not working as well as they should in supporting and driving improvements. They did not always identify concerns promptly and support the management team in addressing them.

Recorded mealtime checks showed that people had access to condiments on their tables. However, we saw this had deteriorated and they were not widely available in the dining room. One person commented, "There used to be salt, pepper and vinegar on every table. Now we're down to one for the whole room." The staff member present acknowledged they were aware of this and did not know where the rest had gone. They borrowed from one table for another person to use, who could otherwise have helped themselves.

Feedback to us, following a visit by staff from the local authority safeguarding and quality assurance teams, identified that record keeping was not good enough. We found that audits of records for both people and staff had not always identified gaps and inconsistencies. For one person where we had concerns, some staff used a 'communications book' and some used the person's individual records. This compromised the way the service could show they consistently met people's needs.

The checks on records had not identified inaccuracies in the way staff calculated one person's body mass index so that their risk of poor nutrition and any potential link to risks to their skin integrity were accurately assessed. Checks on recruitment files had not identified the gaps in information required by law, and checks on the safety of the premises did not identify the concerns we found and which placed people at risk.

The registered manager had an action plan in place to address the local authority's concerns about the prevention and control of infection. In response to the external audit, some actions remained outstanding, including the replacement of all 'swing' bins with pedal bins. This was so that staff did not have to touch the lids when they were disposing of items, risking infection. The registered manager showed us that they had ordered suitable bins, but were having difficulties with the supplier. They were also able to show us how there were major works planned to improve arrangements for handling laundry so that this was a safer process in controlling potential infection.

However, routine checks within the service had not identified additional concerns for the control and management of infection. For example, we found that the hard surfaces to tables in some people's rooms were damaged around the edges. This exposed the porous filling where the surface had worn away. These tables, which some people used to eat their meals, could not therefore be properly cleaned and risked harbouring germs.

The registered manager completed the process of registering with the Care Quality Commission in June 2016 and that this was their first management role in care services. The registered manager explained to us that he had regular supervision from the provider's regional manager. However, when asked, the registered manager was not able to confirm that they had received any supervision since September 2016. The regional manager's report for March 2017 showed that the registered manager would receive supervision

during the following month. This meant they would not have received structured, formal and individual support to discuss their performance and development needs for more than six months. We considered that the provider's processes in place were not robustly applied to support the development of both the registered manager and the quality of the service.

We found that there was a lack of regular oversight by the provider's representative of audit processes completed within the home. The registered manager explained that the provider's regional manager visited every month. We asked to check the reports from these visits and there were none for January and February 2017. The registered manager confirmed those monthly checks had not taken place. The registered manager explained that they had archived older reports so we were not able to check whether this was a recent shortfall.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The registered manager was aware of the role of the Care Quality Commission and the information they must tell us about by law. They understood the notifications they needed to make. The registered manager was receptive to the preliminary findings we shared at the end of our first inspection visit and took action to address these before we returned to the service. This included checking and correcting records that we found were inaccurate and attending to fire doors, which would not close and compromised people's safety.

Staff spoken with confirmed that there was an open door policy and that the manager, deputy and senior staff were approachable. They told us they could raise concerns and report poor practice. They said they were confident they would be listened to and that the management team would take action if necessary.

However, we noted that teamwork was potentially a problem. Concerns about a lack of teamwork and staff arguing amongst themselves were expressed by the management team, at a staff meeting in January 2017. They were aware of the need to make improvements in this area and to staff sickness levels, which were higher than other services in the group. We also noted that some feedback from staff in February 2017 suggested there could be improvements to the way that staff felt part of the team. During this period, the registered manager had not received proper supervision in order to discuss these issues and identify how to drive improvements.

People, their visitors and staff were encouraged to express their views about the quality of the service, both formally in surveys and informally to the manager. We noted that there were pamphlets available to people about what they should expect from care services and how they could make their views known. There was a computer tablet fixed at the reception area so that relatives could add their views. Minutes from the residents and relatives meeting in October 2016 showed that the registered manager reminded people and visitors that this was available to them. There was also information about how people could comment on an external website. In one of these reviews a visitor commented, that, "The manager is excellent and always has an open door to discuss anything necessary."

During our inspection, visitors told us they were happy with the service. For example one said, "I'm very happy with the care [person] has had. I think it's well managed. I fought for my [family member] to come here and I'm glad I did." A person living in the home described the service as, "…fantastic, well-led, I can recommend it."

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not always assessed and mitigated so they could be sure of receiving safe care and treatment. This included risks associated with the premises, in the event of fire and from hot surfaces as well as potential risks arising from inconsistent moving and handling practices. Regulation 12(1) and (2) (a), (b), (c), (d) and (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Although people had the opportunity to express their views about the service and the registered manager was approachable within the service, the provider's systems for supporting good governance were not operating effectively. This included not effectively monitoring the quality and safety of the service, assessing and mitigating risks, and for the accuracy and completeness of records. Regulation 17(1), (2)(a), (b), (c) and (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not operated

effectively to ensure only fit and proper persons were employed and that they were of good character.

Regulation 19(1) (a) and 19(2) (a)
Schedule 3