Wellburn Care Homes Limited

Wellburn House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Wellburn House is a residential care home based in Ovingham, Northumberland which provides personal care and support to up to 35 older people. Some people who live at the home have dementia care needs.

The last inspection of this service took place in January 2016 when the provider was found to be in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment and Good governance respectively. At that time the service was rewarded a rating of 'Requires Improvement'. Following that comprehensive inspection, the provider sent us an action plan in which they told us what they planned to do to meet the relevant legal requirements they had breached.

This inspection took place on the 11 and 12 May 2017 and was unannounced. We carried out this inspection to check that improvements had been made and also to carry out a second comprehensive inspection in line with the revisit timescales associated with the rating the provider was given at our last inspection. We found that in relation to the concerns identified at our last visit, improvements had been made. However, further evidence of shortfalls in the same regulations were also identified.

A registered manager was in post at the time of our inspection who had been registered with the Commission to manage the carrying on of the regulated activity since December 2016. 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.

People told us they felt safe living at the home and in respect of the care that they received. However, we identified shortfalls with the management of medicines which indicated that people did not always get the medicines they were prescribed. Some people were regularly asleep or refused their evening medicines and this pattern had not been identified and addressed by the registered manager or staff. This included people who needed anticoagulant medicines to reduce the risk of blood clotting and epilepsy medicines to control seizures. In addition, recording around the administration of topical medicines was not robust and body maps in place to support staff with where and how often to apply particular creams and ointments, were not always complete.

Risks associated with people's care had not always been identified and addressed. Environmental risks had also not been identified such as fire exits that opened onto staircases not being fitted with appropriate exit controls to prevent people with cognitive impairments from exiting through them, before staff could reach them. Other risks associated with the electrical installation of the building had been identified through an electrical inspection of the home, but remedial work to make these safe was not always carried out in a timely manner.

We also identified shortfalls with the management of people's care records. Care plans and risk assessments were not always in place for key needs that people had. In addition, some recording throughout the service was poor. We found gaps in recording around the administration of topical medicines, there was not always enough detail in daily notes and a lack of completeness and detail in records related to the monitoring of the care people received, and contact with healthcare professionals.

Whilst there were a range of quality assurance checks and audits undertaken, these were not always effective. There was also a general lack of management oversight of the service. The shortfalls that we identified at this inspection had not been identified through the provider's own auditing and checking systems, neither were they identified during visits undertaken by representatives of the provider organisation on a monthly basis.

We received mixed feedback about the registered manager and her leadership style. We discussed this with the nominated individual who took steps following our inspection to look into this matter and some of the issues raised.

Safeguarding policies and procedures were in place and staff understood their own personal responsibilities to safeguard people from harm and abuse. Recruitment procedures were thorough and accidents and incidents were recorded and reviewed to see if measures needed to be put in place to help prevent repeat events.

Staffing levels were sufficient on the days that we visited although staff said these could vary day to day and there were some shifts where they were very busy due to reduced staffing levels. All of the people we spoke with raised no concerns about staffing levels.

Staff were supported with relevant training, supervision and appraisal, in order to deliver care in line with people's needs. Some staff told us where there were issues with their performance, this was not always clearly communicated to them.

People raised no concerns about the way in which they were treated and how their care was delivered. Our observations of care confirmed that staff were pleasant and supportive in their approach and they protected and promoted people's independence, privacy and dignity. We saw staff engaged in pleasant conversation with people and involved them in the delivery of care offering explanations and information when required. Activities were on offer within the home and people were supported to make their own day to day choices. The care people received on a day to day basis was person centred.

The provider had a complaints procedure in place that was brought to people's attention in a service user guide that they were issued with when they started using the service. Relatives also told us they were aware of how to complain should this be necessary. Feedback from people, their relatives and staff about the standards of care delivered, was obtained via questionnaires and meetings held regularly within the service.

Overall people's healthcare needs were met and when they presented as physically unwell appropriate input into people's care from general practitioners and other relevant healthcare professionals was obtained. There were shortfalls however in the respect that risks and poor management of medicines which may have had a direct impact on people's health and wellbeing, were not always identified by staff and management. People's nutritional needs were met and where they needed their food cut up or softened for example, this was done for them.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The

Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act and the registered manager told us they assessed people's capacity when their care commenced and on an on-going basis when necessary. They also told us that decisions were made in people's best interests when necessary, although records about such decision making and any associated capacity assessments needed to be improved. This was being reviewed at the time of our inspection by the compliance manager.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 12 entitled Safe care and treatment, and Regulation 17 entitled Good governance. You can see what action we have asked the provider to take at the end of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Some people did not receive the medicines they were prescribed and this had not been identified by staff or management.

Record keeping around the administration of medicines was not robust.

Other environmental risks had not been appropriately identified and assessed.

Staff were aware of how to safeguard people from harm and abuse.

Staffing levels were sufficient on the days that we inspected.

Accidents and incidents were recorded and reviewed for appropriate preventative measures to be put in place where necessary, to avoid repeat incidents.

Recruitment procedures were thorough.

Is the service effective?

Requires Improvement

The service was not always effective.

People gave generally positive feedback about the care they received.

On a practical level staff were clear about how to support people in line with their individual needs. People's nutritional needs were met.

Overall people's general healthcare needs were met but some concerns related to medicines management had not been identified or responded to appropriately.

The service acted in line with legal requirements around the Mental Capacity Act 2005 (MCA), but evidence of this was limited and records around best interest decision making needed to be

improved.

Staff were trained and supervised but proof of training was not always obtained before staff started work and where there were staff performance issues, staff had not always had these concerns shared with them clearly and formally.

Is the service caring?

Good

The service was caring.

People enjoyed good relationships with staff and staff displayed a caring and positive manner when supporting people with their care.

People were offered explanations before and during care delivery and they told us they felt informed about their care.

Independence was promoted and people's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual care records did not always contain all of the relevant and necessary information about how to care for them appropriately and manage the risks they were exposed to in their daily lives.

Recording standards throughout the service were not always good.

People's care was person centred on a day to day basis. Activities were on offer and people were supported to make their own day to day choices.

A complaints policy and procedure was in place and feedback about the standard of service delivered was gathered via questionnaires and meetings with people, their relatives and staff.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of management oversight and effective governance.

Audits and checks were carried out regularly but these had failed to identify the shortfalls that we found during our inspection.

Some risks had not been identified by management such as people not receiving their medicines as prescribed and those associated with poor record keeping.

We received mixed feedback about the registered manager's approach and leadership style from people, relatives and staff.

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Detailed findings

Background to this inspection

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

This inspection took place on 11 and 12 May 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

We did not request a Provider Information Return (PIR) in advance of our inspection. A PIR 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. However, we obtained feedback about the service from the relevant local authority safeguarding team and contract and commissioning team who worked with the service. In addition, we reviewed information that we held about the service, including statutory notifications, serious incidents and safeguarding information that the provider had notified us of within the last 12 months. Notifications are submitted to the Commission by providers to inform us of deaths and other incidents that have occurred within the service, in line with the legal requirements of the Care Quality Commission (Registration) Regulations 2009. We used the information that we gathered pre-inspection to inform and direct our inspection activity.

During our inspection we spoke with seven people who used the service, three people's relatives, ten members of staff, the nominated individual who is the provider's representative, the registered manager, the compliance manager, the provider's 'In-house' trainer and the deputy manager. We observed care delivered by staff and reviewed a range of records related to people's care and the management of the service. This included looking at five people's care records, five staff files (including recruitment, training and induction records), five people's medication administration records and other company based records related to quality assurance and the general operation of the service.

We reviewed all of the information that we gathered prior to and during our inspection, and used this information to form the basis of our judgements and content of this report.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we identified concerns related to radiator covers within some communal areas and bedrooms. Several communal corridors and bedrooms had radiator covers in place that had wide spaced metal bars and presented an entrapment and injury risk. Since our last visit to the service the provider had refurbished most of the communal areas in the downstairs areas of the home and this included replacing some radiators and radiator covers, with more modern radiators with smooth edges that were cool to the touch. The registered manager and nominated individual told us that refurbishment of the home and the replacement of radiators was to continue in the coming weeks. Radiators that had bars in front of them had been isolated so that the risk of injury was minimised should someone fall against them. In people's bedrooms where these radiator covers were in place, risks were managed (whilst they awaited refurbishment), as access to the front of these radiators was restricted to avoid people coming to any potential harm.

At our last inspection we also highlighted that staff were at risk of injury due to baths not lowering and raising to assist them when they helped people to wash. At this visit we saw one bathroom had been fully refurbished and a high-low bath was now in place. The registered manager and nominated individual told us that the remaining bathroom and bath were due to be refurbished and replaced in the coming weeks, in line with the provider's currently on-going refurbishment programme.

Although the provider had taken steps to address the risks associated with radiators and bathing facilities following our last inspection, at this inspection we identified shortfalls related to the management of medicines within the service.

We found that some elements of medicines management within the service were robust, such as the disposal of medicines, storage and ordering. However, people did not always get the medicines they needed at the right time. We looked at five people's medicines administration records (MARs) and in each case saw that people were regularly missing their medicines on an evening, the majority of times because they were asleep at the time of administration. Some people had not received their evening medicines for a number of consecutive days, because they had refused to take them. One person had not received their evening dose of their anticoagulant medicine for six out of eight days between 3 and 10 May 2017. Another person had not received their epilepsy medication 11 times out of a possible 14 times in the evening, because they had either been sleeping at the time of administration, or they had refused. No attempt had been made by staff to re-administer these medicines at a later time, and other than in one case, no referrals had been made to people's general practitioners to seek advice about them refusing, or not receiving their medicines regularly.

Staff had not recognised the risks associated with people failing to receive the medicines they needed to control and support their health conditions. This meant people's health and wellbeing was put at risk because they did not get the medicines they were prescribed to take at the right time.

"When required" medicines care plans had been put in place since our last visit to the service and topical medicines administration records and associated body maps were in use. However, there were gaps in

recording around the administration of topical medicines particularly, and body maps were not always completed detailing what topical medicines to apply, to which part of a person's body.

Risks associated with people's care were not always identified and mitigated. For example, one person had an airflow pressure relieving mattress in place but this was set to the wrong setting for their weight and this had not been identified by staff or management. There was no information about what setting this should be set at in their care records. Other people were exposed to risks and staff knew how to manage these risks in practice, but no formal risk assessments had been carried out and documented. Some care records had risk related information merged in with care plan information and it was not always clear to the reader how to manage risks.

Fire doors on the upper floor could be opened by people and these led onto both internal and external staircases. One of these fire exit doors looked like a bedroom door and had a lack of signage in place on the door itself. Although the fire doors were alarmed to alert staff should any person open them, there was a risk that the people living on the upper floor with dementia care needs may open these and fall down stairs before staff had a chance to reach them. The registered manager and provider had not identified this risk themselves. We discussed this with the nominated individual who advised following our inspection that they had made arrangements for an assessment of these fire doors to take place and they would look to have exit controls fitted that people cannot tamper with.

We viewed the electrical installation checks carried out on the building and saw that these had graded the installation as 'Unsatisfactory' and confirmed it was not up to current British standards. We saw that a five year electrical installation check had been carried out in May 2011, remedial work undertaken in June 2012 to address dangerous and potentially dangerous issues and a further electrical installation check carried out in early April 2017. This latest check has also graded the electrical installation in the building as 'Unsatisfactory'. The deputy manager told us that work to address the latest issues raised is due to be carried out in June 2017. This showed that risks associated with health and safety matters within the building were not always addressed in a timely manner as there were delays between potentially dangerous electrical conditions/issues being identified and action being taken to correct these.

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

People told us they felt safe living at the service and when receiving care from staff. Relatives echoed their feedback saying they had no concerns about their family member's safety. One person told us, "I have not felt unsafe here and I have never been hurt". Another person said, "The staff are very good on the whole. They don't do bullying or anything". One relative told us, "I have no concerns at all about the staff".

We observed staff when they delivered care and had no concerns about people or their safety. Moving and handling procedures were carried out safely and in line with best practice guidance.

Staff were aware of their personal responsibilities to report matters of a safeguarding nature should they arise. They were clear about who to report safeguarding concerns to and showed a good knowledge of the different types of harm and abuse that people could be exposed to. Staff had completed safeguarding training in their roles. Matters of a safeguarding nature had been reported to the local authority safeguarding adults team for investigation in line with set protocols. Statutory notifications about safeguarding incidents that occurred within the service had been received when relevant since our last inspection.

Accidents and incidents that occurred within the service were appropriately recorded and reviewed. Action was taken where necessary to prevent repeat events.

Health and safety checks, additional to the electrical installation referred to above, were carried out regularly to ensure people's safety. These included a range of fire safety checks, building checks, legionella control measures, window restrictor checks, and checks and servicing of equipment used in care delivery, such as hoists, nurse call bells and wheelchairs. A range of risk assessments related to the building and environment were in place. However, with reference to the breaches identified above, although these checks were done, staff completing these checks did not always identify concerns with the safety of the building or environment.

Personal emergency evacuation plans (PEEPS) had been drafted and were in place for those people who would require assistance to leave the building in an emergency situation such as a fire or flood. In addition, a business continuity plan was in place for staff and management to follow in the event of a range of unforeseen circumstances arising, such as a loss of power to the building.

Staffing levels within the service were sufficient to meet people's needs on the days that we visited. Staff shared some concerns with us that at times staffing levels were higher than others and this was not consistent leading to them being under pressure some days due to staffing shortfalls. However, we did not witness this on the days we visited and staffing levels were such that people had their needs met in a timely manner. Rotas reflected what staff had told us that staffing levels varied but these were not reduced to unmanageable levels. People told us that staff were readily available to them and that whenever they needed to summon assistance via their call bells, staff came promptly. One person commented, "I think there are enough staff. I don't have to wait too long". Another person said, "If you want them you press the call bell and they come. I have one in the toilet and one on my walking frame too, plus this call bell around my neck".

We reviewed a number of staff files at this inspection and found that recruitment processes were robust. Prior to our visit we received anonymous concerns that staff were working at the service without Disclosure and Barring Service (DBS) vetting checks being carried out in advance, to ensure they were suitable to work with vulnerable people. The DBS help employers make safer recruitment decisions as they carry out checks about people's criminal backgrounds if any, and also compare their details against a list of people barred from working with vulnerable adults and children. We asked the provider for information about staff start dates and DBS checks in advance of our inspection. During our visit we reviewed procedures and records related to people's vetting checks and start dates. We found no evidence that people worked alone at the service delivering care before their DBS results had been received. The nominated individual confirmed that some new staff did enter the home to complete training and shadowing of other staff in advance of their vetting check results being received, but they were always accompanied and this had been agreed with the local authority commissioning teams to ensure the smooth transition of staff during a time of high staff turnover.

Other elements of recruitment were thorough, people completed application forms, gave information about their employment history, presented identification and references were obtained by the provider and verified. Staff records showed that disciplinary procedures were followed where necessary.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the care and support they received. One person said, "I like it here. It's been alright and the food has been tasty". Another person told us, "It is very good here. The staff are very obliging". Other comments included, "All the staff are fair enough. Like this girl (staff member walking past); she is always checking that I am drinking my cup of tea" and "They are looking after us well here. We know what we want and we get it".

Relatives gave mixed feedback about the service and the care that they saw delivered at the home. One relative commented, "The care is a bit of a mixed bag really. Sometimes they haven't rang me when there has been a doctor. There has been lack of communication, although this is getting better now". Another relative told us, "The care is very good from my point of view. We haven't come across any problems at all".

We observed care being delivered throughout the home. We saw that on a practical level staff were clear about people's needs and how to support them appropriately. In addition, when we asked staff about particular people's needs and behaviours, they were able to explain these in detail to us and they clarified how they would support these people to manage their needs. The information they gave us tallied with information held in these people's care records and our own observations.

Overall people's general healthcare needs were met. The concerns we identified with people not always receiving their prescribed medicines had not been referred to their general practitioners in most cases. However, where people presented as physically unwell, visits from their general practitioners had been arranged. In addition, where input into people's care from specialist healthcare professionals such as speech and language therapists (SALT) was needed, for example, in relation to people with swallowing difficulties, this specialist care had been arranged. Some records related to input from external healthcare professionals were not well maintained, but those that were demonstrated that people were supported to receive reviews of their health from opticians, district nurses and chiropodists.

People's nutritional needs were met. One person who did not eat independently was encouraged to do as much as possible for themselves, and food was cut up into small chunks so that they were not put off consuming it. One person had been referred to the SALT team for assessment in relation to their swallowing difficulties. The kitchen chef told us that any changes in people's nutritional needs were shared with them as soon as practicable and there was a file in situ in the kitchen which listed people's preferences and any requirements for special food consistency, such as mashed or softened food. Staff told us that nobody currently using the service required a pureed diet.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care

homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications for Deprivation of Liberty Safeguards (DoLS) had been made to the local authority safeguarding team in accordance with good practice and reapplications made when granted safeguards had expired. 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were in place where people had consented to these, and where they were unable to consent, a communal decision instigated by a clinician had been made.

The registered manager told us that decisions which needed to be made in people's best interest in line with the MCA were taken in conjunction with their families and care managers. However, documentary evidence to support this was limited within people's care records. Documentation around the application of the MCA was under review at the time of our visit by the compliance manager. New paperwork to capture capacity assessments that were undertaken and who was involved in decision making was being introduced.

Across people's daily lives they were asked for consent to care and treatment. For example, we heard staff asking people if they wanted to move through to the dining room for lunch, if they wanted to walk with support or use equipment and if they were ready for their medicines. This showed that staff understood people's right to consent to care and they respected this right.

Records showed that staff received regular training via e-learning and face to face courses, which were relevant to their roles. The registered manager and deputy manager were responsible for monitoring training requirements and making arrangements for training to be refreshed as and when required. Staff told us that they received regular training some of which was delivered by an in house trainer who worked for the provider. An induction programme was in place and completed by new members of staff at the point they commenced employment with the service. We identified that a small number of staff who had moved to the service from other care settings had already completed care based training in key areas such as medicines. However, they told us that they had not been asked by the registered manager to bring their relevant certificates in to prove this. Other staff confirmed that they had been asked to present their training certificates as proof of completion of training when they started in post. We discussed this matter with the nominated individual so that they could investigate this further and ensure that in all cases, steps were taken to verify the training new staff had already completed before they started working at the service.

Staff confirmed that supervisions took place regularly and appraisals annually. Supervisions and appraisals are important as they are a two-way feedback tool via which individual staff and their line manager can discuss work related issues, performance, training needs and personal matters if necessary. Some staff told us that they were subject to a performance monitoring plan, although this had not been formally discussed with them in a supervision session, and they were not clear what was expected of them or how exactly they needed to improve in their roles. We looked at relevant paperwork and found that ongoing performance plans for the relevant staff had not been documented and retained within staff files. This showed staff did not always receive clear messages about their performance as where there were concerns, these were not relayed to individual staff in a clear, formal manner. The registered manager accepted our findings and said she would ensure any performance related issues were appropriately documented in staff files in the future.

Throughout the home the environment was clean, tidy, spacious and well maintained. The provider had a refurbishment plan in place and this was ongoing. Work was due to commence in the weeks following our inspection in the areas of the home where redecoration and refurbishment had not already taken place. Where areas had been redecorated they were homely, nicely furnished and presented. This work had been

carried out since our last visit and the home looked more modern and fresh as a result. People and their relatives said they appreciated the new improved environment. There were adequate facilities such as communal areas and bathrooms and toilets for people to access. Consideration had been given to the environment so that where appropriate, people with dementia were supported in line with their needs. For example, pictorial and written signage was now in place to orientate people, for example, to the dining room or toilets. People had access to outdoor space in the form of an enclosed garden area and a patio decking area with seating was available for use outside a sun room at the front of the home.

Good

Is the service caring?

Our findings

People told us they enjoyed good relationships with the staff team who supported them and our own observations confirmed this. We observed many pleasant, kind and courteous interactions between people and staff. One person told us, "The staff are super and easy to get on with. Everything runs smoothly here". Another person told us, "The staff have been kind to me. I like it here". One relative commented, "They (staff) are very nice with my mum".

Staff regularly asked people if they were alright, if there was anything they could do for them and they encouraged people with their mobility, praising them for their achievements. We observed staff encouraging people to finish their meals, to walk slowly and carefully and they offered a gentle helping hand when needed. We heard comments from staff directed to people such as, "Don't worry I have got your bag for you", "That's great", "Thank you", "Well done" and "That's it (person's name), stand up nice and tall for me". One staff member said to a person when questioned why they were smiling at them, "I am just giving you a smile because you always give a lovely one back".

Staff thanked people for their patience when they waited to be assisted at busy times. They explained why they were not available immediately and gave people a timescale as to when they would return to help them, asking people if that was acceptable, which it was.

People were involved in their care and they were offered explanations before care was delivered. For example, one lady who was anxious during hoisting manoeuvers was involved in the process and a range of explanations were given before each manoeuver started. She was encouraged to hold straps and staff explained what the sling was for before being placed onto her body. Another person was encouraged to feel the chair behind them on their legs before attempting to sit down independently. One lady who had a hearing impairment was supported by a staff member with an amplifying headphone set. The staff member spoke into the device which relayed the speech into the headset so the person could hear them and follow instructions about how to move themselves safely from their chair into the dining area for lunch. The use of this equipment meant the person concerned could be much more involved in their care than if it was not used.

People were provided with information about the service in the form of a service user guide that was available in their room for reference. This contained information about services on offer within the home, plus reference to the provider's complaints policy and procedure should people need to raise any concerns.

People told us their privacy and dignity was respected and promoted and our observations confirmed this. We observed staff discreetly speaking to people when highlighting they had not eaten much in order to protect their dignity, or when asking if they wanted a clothes protector on to remain clean when eating. Staff sat at the same level as those people that they supported to eat, so that they were not towering over them in an undignified manner. One person who was struggling with discomfort in their legs had a blanket over them and staff were mindful of checking and repositioning the blanket when it had moved, in order to keep

the person's legs covered in a communal area. Staff explained how they promoted people's privacy and dignity, for example by knocking on doors before they entered people's bedrooms, and covering their bodies when delivering personal care so that they were not exposed.

Throughout our inspection we saw staff promoted people's Independence as much as possible. Where they knew people were capable of feeding themselves but they were reluctant to do this, we saw staff provided gentle encouragement so that people did as much as possible for themselves without assistance, in line with their abilities. Some people had assistive cutlery available to them and specialised drinking cups to enable them to eat independently. A large proportion of people moved around the home independently with or without walking aids. Staff encouraged them to do so, whilst watching over them where necessary to make sure they remained safe.

Equality and people's diversity was respected and promoted. We saw no evidence to suggest anyone who used the service was discriminated against and no one told us anything to contradict this.

The registered manager told us that no person living at the home at the time of our inspection accessed the services of a formal advocate, but that should this be necessary, clear procedures and contact details were in place about how to arrange this type of support. People's relatives also advocated on their behalf in decision making when appropriate.

Requires Improvement

Is the service responsive?

Our findings

People's care records were not always well maintained and they did not always contain enough information about people's specific needs and associated risks that they were exposed to. For example, one person who had recently displayed behaviours that placed themselves and others at risk, did not have a specific care plan or detailed risk assessment in place for staff to refer to when delivering care. Another person had recently sustained an injury and although in practice staff knew how to manage their care and reduce risks, there was no specific care plan or associated risk assessment for them to refer to for support and guidance. Some care plans contained information about how to support people and how to reduce risks, however, this information was not always clearly defined and separated in the text of the plan to assist the reader. Some care records contained contradictory information about people's needs.

Records related to contact with, and visits from external healthcare professionals, were said to be maintained via a grid in people's care records, according to the registered manager and deputy manager. However, in several care files we saw no entries had been made to show that, for example, a general practitioner had visited, despite the registered manager, deputy manager and staff telling us about a recent visit or contact. When we checked the daily notes for each person for the dates we were told a healthcare professional had visited, we found no detail about the reason for the call, the feedback given to the home by professional, the actions they needed to take and the outcome for the person concerned. Other general recording around care delivered fell short of acceptable standards, such as a lack of accurate recording around medicines, bathing and hygiene care. Some records were not complete, as dates and key information was missing.

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

Although some people's care records lacked detail and they were not always complete, they were individualised and person-centred. There was a basic life history in place for staff to refer to about peoples' past lives and what they had achieved and enjoyed throughout their lives. Pre-admission assessments had been carried out before people started using the service to determine their level of dependency and needs. Care plans and risk assessments were regularly reviewed and updated to reflect changes in people's needs, although as referred to above, there were some gaps where changes in people's needs had not been recognised and appropriate records drafted and maintained. People had care plans in place for a range of needs such as mobility, nutrition, falls, communication and skin integrity.

Care monitoring tools were used to ensure that people's care was delivered appropriately and changes in their health and presentation were identified promptly. For example, people's food and fluid intake was monitored where they had specific nutritional needs or where there were any concerns about their intake. Any significant changes in their weights were reported to the registered manager for assessment and appropriate action to be taken. Two- hourly night time checks were also carried out and recorded to ensure that people had everything they needed and they remained comfortable and safe.

A verbal handover took place when staff shifts ended and began, and this was supported by a written handover sheet and a communication book where key messages or monitoring of people's conditions were passed between team leaders on each shift. Daily notes were maintained which showed evidence of personal care delivered, activities people had undertaken, their general mood and any issues, amongst other things. This showed that measures were in place to support continuity of care.

The care people received on a day to day basis was person-centred. They displayed positive moods and their general care needs such as eating, mobility and continence, were met. One person told us, "I am quite content here with what they do for me". Where people presented as unwell or had lost weight staff were responsive to their needs and they had involved GP's and specialists in their care when needed, to promote their health and wellbeing. However, as highlighted previously in this report, there were some concerns related to people's safety that had not been identified by staff and management, and therefore they had not been appropriately responded to.

Transition between services and associated continuity of care had been considered as people had hospital passports in place. Hospital passports are documents which provide hospital or other healthcare staff with an overview of people's current or past health issues, and any details about how people like to be supported.

People told us there were a range of activities on offer within the home, however on the days that we visited there were no activities scheduled to take place. People enjoyed time watching television and talking with staff. One person told us, "They have activities but you don't have to go if you don't want to. I like to stay in my own room". Another person said, "I think we do very well here. We have singers and things to do".

People were encouraged and supported to make choices for themselves. We heard staff ask people what they wanted to eat for their dinner, where they wanted to sit and if they wanted support and assistance with specific tasks. People told us they were able to make choices and they had as much control and independence in their lives as possible. One person said, "We get choices" and another told us, "It has been much nicer than I thought here and there have been no ridiculous rules. You can decide".

Feedback from people and their relatives was obtained annually via questionnaires. People told us they had completed these. In addition, meetings for people who used the service and their relatives were held regularly, as were meetings for the staff team. These meetings and questionnaires provided a channel via which the provider could gather opinions from a range of people about the standards of service they delivered. Any feedback gathered enabled the provider to focus their efforts on where actions and improvements were needed.

The provider had a complaints policy and procedure in place that was brought to people's attention in the service user guide that they were issued with at the point they started using the service. We saw that people had these documents in a document wallet secured to their walls within their rooms for reference purposes. People told us they were happy with the service they received but that if they were not, they would tell a member of the staff team or the registered manager directly. One person said, "There is nothing to complain about and even if there was something little, life's not perfect anyway is it"!

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the provider was not compliant with Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 because their governance and oversight of the service was not effective enough. At that time, records about staffing levels were not well maintained, there was a failure to identify risks associated with inappropriate radiator covers and safeguarding incidents had not been reported to the local authority safeguarding adults team for assessment and potential investigation. At this inspection we found these previous concerns had been addressed, however, we identified new concerns related to the effectiveness of the provider's auditing and governance systems, and the general management oversight of the service.

A range of detailed audits and checks were carried out regularly, for example, related to care plans, the management of medicines, accidents and incidents, finance and health and safety. The manager carried out a weekly audit of the environment of the home and the provider's representatives visited the home monthly to review all of the auditing that had taken place. Action plans were used on the back of each audit where there was a need to undertake any follow up work. The visits carried out by the providers' representatives were summarised in a report and an action plan was drafted for the management team of the home to progress.

However, the care plan audits had not picked up the shortfalls that we found with care planning and risk assessment documentation, or some of the lower standards of recording throughout the service. The medicines audits had not identified the risks to people's health and wellbeing that we identified in relation to them not receiving the medicines they were prescribed. In addition, there was a lack of leadership and management oversight to ensure staff completed topical MARs in line with best practice guidance.

Health and safety risks such as the potential for people with dementia to easily exit the building through fire exits which led onto staircases, had not been identified by management or the provider representatives. Alarms were in place to alert staff if people opened these exits but they were not tamperproof or key-coded. Records showed that following the electrical installation check carried out on the building in 2011, the provider had addressed the concerns identified, but this was not in a timely manner as it was almost a year later. The most recent electrical installation inspection carried out in April 2017 highlighted further potentially dangerous conditions, which, at the time of our visit some six weeks after that inspection, had not been addressed. Where one person was at risk of pressure damage, poor maintenance of records and a lack of management oversight had impacted on their care, as their airflow pressure mattress was not at the correct setting to protect their skin integrity and this had not been identified.

Although the provider had embedded their own monthly visits and checks of the auditing of the service, these had failed to identify the concerns and breaches in relevant regulations that we found at this inspection.

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

As part of quality assurance systems within the service, staff supervisions and appraisals were carried out regularly. Assessments of staff competency in administering medicines were also done to ensure that staff followed best practice guidelines. The provider also gathered feedback from people and their relatives through questionnaires and meetings, and they used this information to look at ways to improve the service delivered.

At the time of our inspection there was a manager in post, who had been registered with the Commission to manage the carrying on of the regulated activity since December 2016. The registration requirements of the service had been met and we were satisfied that incidents had been reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009. The provider had one particular service user band on their registration for this service that was not relevant and the registered manager told us they would arrange for an application to be submitted to get this removed.

We received positive feedback about the registered manager from people and their relatives. One person told us, "The manager is fine" and another said, "Oh I like the manager". One relative told us, "The only problem I have had is that the manager doesn't always ensure I know when my mum has fallen". Another relative commented, "(Registered manager's name) has been fine. If we have had any concerns she has always helped us out. If there is anything we have needed to know we have found it out".

Some staff raised concerns with us about the leadership style adopted at times by the registered manager. Some staff told us they found the manager approachable and supportive and others said they did not. Some staff gave examples of how the registered manager's approach towards their colleagues, had at times led to a difficult relationship and tentative atmosphere between the staff team and the registered manager. However, they reported they believed the registered manager was trying to drive improvements within the home and may not be aware of the impact of some of their actions. We discussed this feedback with the nominated individual who told us they would look into the concerns raised by staff. Following our visits to the home, the nominated individual has informed us of the positive steps they have taken to support the registered manager and staff in improving their working relationships.

The registered manager and nominated individual were receptive to all of the feedback from our inspection and they showed a willingness to address each of the individual concerns that we identified as soon as possible.

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 The management of medicines was not robust. People did not always receive the medicines they were prescribed on time. Risks that people were exposed to in their daily lives, including environmental risks, were not always identified and addressed. Regulation 12(1)(2)(a)(b)(g).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Monitoring and auditing systems were not effective. There was a lack of management oversight to ensure people's health and safety. The provider did not identify the shortfalls with medicines and risks to people's health and wellbeing that we found during our inspection. Care records and other records throughout the service were not always well maintained. Regulation 17(1)(2)(a)(b)(c).

The enforcement action we took:

We have issued a warning notice in respect of this regulation.