Care Quality Commission

Selborne Court Res Home

Selborne Court

Inspection report

110 Bulls Head Lane
Stoke Green
Coventry
CV3 1FS
Tel: 024 7645 3050

Date of inspection visit: 8 September 2015
Date of publication: 13/11/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We carried out an unannounced inspection of Selborne Court on 8 September 2015.

Selborne Court provides personal care and accommodation for up to 20 older people. There were 18 people living at the home when we visited.

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

We found people's needs were not always met in accordance with their preferences. People's care plans identified their care needs but they contained insufficient information to support staff in delivering person centred care. This meant people may not always receive care in accordance with their wishes. For example, some people

Summary of findings

stated they would like more social interaction and activities to be provided. We found there were limited opportunities for people to be involved in social activities and outings.

People were restricted in their choices to have a bath or shower because the showers had steps which meant most people could not access them. People had limited choices of meals because usually there was only one main meal provided each day. Staff did however say an alternative choice would be offered if a person did not like the meal provided.

Quality monitoring systems had not been developed to drive improvement within the home. For example, there were no meetings where people, relatives and staff could offer their opinions and views about issues related to the running of the home. People were not asked through satisfaction surveys if they were happy or unhappy about any elements of the care and services they received. Staff however told us that in their view there was effective communication between themselves and the people that lived there.

Systems and processes in the home had not been implemented in accordance with the current health and social care standards and regulations. Staff were also not fully aware of them and the provider had not ensured this had been addressed as part of their auditing processes.

People we spoke with were overall happy with the care they received and there was a relaxed and homely atmosphere within the home. People told us that staff respected their privacy and dignity when delivering care and we saw this happened. People were well dressed and staff took time to assist people with their personal care needs.

All the people we spoke with told us they felt safe at the home and nobody raised any concerns with us regarding their safety. Staff knew how to recognise abuse and told us they would report abuse if they observed this happening. There had been no safeguarding incidents that had occurred in the home.

Care staff told us they communicated any concerns in relation to people at the handover period between shifts so any risks to people's health and welfare could be managed. There were some plans in place for staff to follow in the event of an emergency, such as a fire, to make sure people were kept safe.

The registered manager and staff had some understanding of the Mental Capacity Act 2005 (MCA). Staff were not fully clear on their responsibilities in relation to the Deprivation of Liberty Safeguards (DoLS) and how potential restrictions to people's care should be identified and managed in particular for those people with dementia.

People received their medicines as prescribed and these were administered by care staff who had completed medicines training. Staff completed essential training such as moving and handling people on an ongoing basis but some of their training was due to be updated. People felt their care needs were being met by suitably trained staff.

All the people we spoke with told us if they needed a doctor the staff would make an appointment for them. We saw that health professionals visited the home to support people's needs when needed. This included physiotherapists, chiropodists and opticians.

We found there were two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe and there were sufficient staff employed by the home to support people's needs. Staff understood they had a responsibility to protect people and report any concerns they identified to their manager to make sure they were kept safe consistently. People received their medicines as prescribed to manage their healthcare needs.

Good

Is the service effective?
The service was not consistently effective.

Staff had completed essential training to enable them to carry out their role but some of their training was overdue. Staff did not have a good understanding of Deprivation of Liberty Safeguards (DoLS) to make sure people's human rights were respected. People told us the food was good but they were not given a choice of meals and they didn't know what meals they would be having until they were served.

Requires Improvement

Is the service caring?
The service was caring.

People told us staff were caring and treated them with dignity and respect. This was confirmed by our observations on the day of the inspection which showed staff were attentive when providing support. All people within the home had family members who could support them with decision making.

Good

Is the service responsive?
The service was not consistently responsive.

People did not feel they were always involved in their care and this resulted in care records not being sufficiently detailed to support staff in delivering person centred care. People were not given regular opportunities to pursue their hobbies and interests. Social activities and outings were limited as were links with the local community to provide people with meaningful activities and social contact. There had been no complaints received by the service but the provider's complaints procedure was not easily accessible to people.

Requires Improvement

Is the service well-led?
The service was not consistently well led.

Systems and processes in the home had not been implemented in accordance with the current health and social care standards and regulations. Staff were also not fully aware of them and the provider had not taken action to address

Requires Improvement

Summary of findings

this. Effective quality assurance procedures were not in place to assess and monitor the quality and safety of service people received. This meant there were limited opportunities for people to influence decisions and drive improvements within the home.

Selborne Court

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 8 September and was unannounced. The inspection was carried out by an inspector and an expert by experience. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home. We looked at information received from agencies involved in people's care. There had been no concerns received by any agencies. We analysed information on statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home.

We looked at two people's complete care records, we also viewed other care documentation such as people's daily records, weight charts, food and fluid charts and medication records. We looked at the complaints file, accidents and incident records and records and policies and procedures used by staff. We completed observations during the day including over mealtimes in the lounge/ dining area and bedrooms to see what people's experiences of the home were like.

We spoke with ten people, two visitors, three staff members and the registered manager.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at the home. Comments from people included, “Oh it’s good, I had some near misses at home, but in here they keep a check on me.” “Yes we feel safe, when the staff move me I feel safe.”

There had not been any recent safeguarding incidents at the home. Staff confirmed there were policies and procedures in place for them to refer to should they have any concerns regarding safeguarding people. Staff understood they had a responsibility to protect people and report any concerns they identified to their manager. They also knew which agencies should be approached in the event of suspected abuse in the absence of the registered manager. This meant systems were in place to protect people from harm.

Employment checks were carried out prior to new staff starting work at the home to make sure they were of a good character to work with the people who lived there. The registered manager told us they had only employed one new member of staff since our last inspection and all appropriate checks had been carried out. This staff member had completed an application form and had been interviewed twice to ensure they would be suitable to work at the home. Training certificates were available to confirm the training they had completed and a police check had been carried out to make sure they did not have any criminal convictions and were of good character. The registered manager told us the person worked under the supervision of more experienced staff as they were still completing their induction training. The staff member confirmed this information. When we looked at the recruitment files for two staff members, records showed appropriate employment checks had been carried out this included requests for two written references and identification checks.

Where there were risks associated with people’s care, action had been taken to escalate these to health professionals so that any advice on how to manage these could be sought. For example, staff noted that one person became breathless when moved. They sought health professional advice and treatment was prescribed. The registered manager had ensured a care plan was in place with instructions for staff on how to manage this. Staff we spoke with were aware of what action to take which demonstrated they were following the care plan to ensure the person’s needs were met.

We looked at the accident and incident records and identified one person had fallen on several occasions during 2015. We observed staff managed this risk by supporting the person when they moved from the lounge to their bedroom to help reduce the risk of them falling. A risk assessment had been completed which showed the person was at risk of falls due to their blood pressure fluctuating when sitting and standing. There were instructions for staff to “monitor” the person to reduce this risk.

The registered manager told us she reviewed the accidents and incidents on a monthly basis so that she was aware of those that had occurred and to identify any action required to keep people safe.

Personal emergency evacuation plans (PEEPs) were kept on each person’s individual file and were updated as required. This was so it was clear how people would need to be supported safely by staff or the emergency services in the event of a fire or other emergency. We found information in one of these plans had not been updated. However, staff knew about people’s mobility needs and what support they needed. Staff told us about a contingency plan in the event the home would need to be vacated for any length of time. The registered manager was not able to confirm if this information was in the fire procedure for the home to make sure this was clear for all staff and acknowledged the need to check this.

People told us their care needs were met by staff and most of the time there were enough staff available to support them. People told us there were times of the day when staff were busy and this meant that sometimes they had to wait for their assistance. People told us, “I haven’t been here very long but I think there is (enough staff) when you need help to go to the toilet they are there on the spot.” However another stated, “Sometimes you have to wait to go to the toilet, staff are over run.” On the morning of our visit we noticed a person had waited for around 10 minutes to be assisted to the toilet as staff were busy. Staff communicated with the person to let them know they would assist them as soon as possible.

Good

Is the service safe?

Our observations during the day concluded that there were enough care staff on duty, however they had other non-caring duties to complete such as laundry and catering. This meant sometimes people had to wait a short time for assistance. Staff told us that they thought that there were enough of them to keep people safe and meet their care needs but confirmed that there were times when they were particularly busy during the day. We discussed this with the registered manager who told us that she would keep staffing arrangements under review.

The registered manager told us that equipment around the home was regularly checked and serviced to ensure it remained safe for people to use. This included the bath hoist, hospital beds and electrical appliances. Records we viewed confirmed safety checks had been carried out within the required timescales.

Medicines were being appropriately managed. One person who felt they had not had their pain relief told us they reported their concern to the manager so that it was addressed. Medicines were administered by care staff who had completed medicines training. Staff checked medicines prior to administration to make sure people received them correctly. Medication administration record (MAR) sheets had been completed accurately to show that people had received their medicines as prescribed. Where people had been prescribed medicines "as required" such as pain relief tablets, staff had recorded the amount given so that the person was not given in excess of the advised safe amount. We noted when we looked at care records that one person was allergic to penicillin. When we checked this person's medicine records there was no mention of this to ensure the person was not placed at risk of this being prescribed and administered. The registered manager agreed to address this.

Medicines were stored securely in a medicines trolley and the registered manager worked closely with the pharmacy to ensure medicines were ordered on time and safely disposed of.

Requires Improvement

Is the service effective?

Our findings

People told us they received care and support that met their needs and staff carried out their duties effectively. One person told us, "I think staff do know what they are doing, they clean my room, clothes and no-one is allowed in the bath on their own, a staff member always stays; they wash my back and help to dry me."

Induction training was provided for new staff and this involved them working alongside more experienced staff members. They did this for a period of time to help them develop the required level of skills and knowledge to support people safely. A new staff member confirmed they were in the process of completing all of the induction training before they worked independently. It was not evident that consideration had been given to review training in line with the 'Skills for Care' Care Certificate to further support staff in carrying out their role.

Staff told us that the essential training they had completed such as moving and handling people and infection control was good and provided them with the necessary skills to undertake their role. They told us some of their training was due to be updated to make sure they continued to support people safely and effectively. Training schedules were not sufficiently clear to show what training needed to be completed, however, the registered manager told us some of training was overdue and this was being organised. Staff had not completed training in regards to person centred care. When we asked staff about this, they had a limited knowledge of what this meant in practice. This meant staff may not recognise how to implement person centred care to ensure people received care in accordance with their preferences and wishes.

Staff told us they handed over any information of concern about people to staff starting the next shift to ensure any risks associated with their care were managed. Records of the information shared during the handover period were not kept for staff to refer to, this also meant we could not confirm this happened consistently and assess the effectiveness of this process.

New staff, as well as existing staff, sometimes had supervision meetings with the registered manager to discuss their ongoing work performance. These meetings provided staff with an opportunity to discuss personal development and training requirements. A staff member told us they discussed, "How I feel about the place, any problems, how things are going any changes that need to be made." The registered manager told us appraisals were carried out annually to identify how staff wanted to develop in their role. The registered manager told us she planned to hold supervision meetings more frequently which would enable staff training and support to be more effectively managed.

We asked the registered manager about their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the MCA and DoLS and to report on what we find. The MCA ensures the rights of people who lack mental capacity are protected when making particular decisions. DoLS referrals are made when decisions about depriving people of their liberty are required, to make sure people get the care and treatment they need in the least restrictive way. The registered manager and staff were able to explain the principles of MCA which showed they had some understanding of the legislation. There had been no DoLS referrals made. The registered manager and staff had a limited understanding about DoLS and when a referral should be made to enable decisions to be made in the person's best interests. The registered manager agreed this was an area where they and staff would benefit from further support and training and they would arrange this.

We saw people were involved in everyday decisions about their care such as where they sat, what they ate, and what drinks they would like. Some people were independent with some of their care so did not always require staff support.

People said the food was good but most people did not know what meals they would be receiving. Choices provided to people were limited in that there was a main meal provided each day that was usually a roast dinner. Staff told us the main meal was something everyone liked and if anyone did not want this, they would provide them with an alternative choice. Comments from people about the food included, "Good, very good there is a menu by the front door. Staff know who don't want what. I can't chew the mince so they do me sausages or faggots; there is always something you can have." "It's good, certainly too much for me. There is no menu, I don't know what we are having until it arrives, the puddings are very good." It's

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Is the service effective?

good, not bad really." When we asked people what happened if they did not like the meal provided they told us, "Well you hope to God you like it." "Nothing, I just leave it, I don't like to say."

We discussed the limited choices of meals with the registered manager and also asked how they ensured all meals provided were nutritious. The registered manager told us this was something she would need to review. However, we were told people would be offered an alternative if they stated they did not like the main meal provided.

Where people were not eating and drinking sufficiently to maintain their health, the registered manager had introduced food and drink charts to monitor the amount of food and drink they had consumed. The food and fluid charts we looked at for one person had not been completed sufficiently to establish whether the person had eaten and drunk enough each day. The food chart did not always show the amount of food the person had eaten and the fluid charts showed on some days they had only had two or three drinks all day. There was no daily target on the charts to indicate to staff how much fluid the person should have each day.

People who needed assistance to mobilise were supported to the dining area to eat their lunch. The dining area had limited space for tables for everyone so some people remained in the main lounge area and ate their lunch from small tables placed in front of them. Staff served everyone with the same meal but explained to people what was on their plate. Two choices of pudding were offered. Staff interacted with people politely and respectfully. They altered their approach and tone of voice in line with each person's communication and hearing abilities. One person refused to eat their meal and staff offered them encouragement. When the person became anxious and refused, staff accepted their decision not to eat anymore. The care staff member who cooked the meal was informed and they stated they would save the person some pudding and offer it to them later. We observed a person in bed was assisted to eat their food at a pace in accordance with their needs. The staff member spoke quietly to the person explaining what the food was which the person responded well to.

Staff spoken with had a good understanding of people's health care needs. All the people we spoke with told us if they needed a doctor the staff team would make an appointment for them. We saw that other health professionals visited the service to support people's needs when needed. This included physiotherapists, chiropodists and opticians.

Good

Is the service caring?

Our findings

People were overall happy with the care they received and there was a relaxed and homely atmosphere within the home. People told us, "The staff are lovely, they are so kind." "Staff are always very pleasant, very caring, we are lucky to be here." Staff had formed good relationships with people and we saw that they interacted with people in a friendly and respectful manner. For example, during breakfast we saw one person became upset. A staff member in response, put their arm around the person and offered them kind words which we saw resulted in the person's anxiety being reduced.

People told us staff did not always have time to speak with them socially because they were busy. When we observed care staff we noted they were busy for periods throughout the day completing laundry and catering tasks in addition to their care tasks. Staff assured us they did make time to speak with people but there were times of the day when they were particularly busy. We made the registered manager aware of our findings so that she could take any necessary actions to address this.

People's religious needs had been considered. The registered manager told us all people were asked when they came to live at the home whether they wished to practice their faith so that arrangements could be made. She told us a chaplain visited the home "now and again" for a chat. Communion was being provided once a week from the local church and everyone was asked if they wanted to participate.

Care plans we looked at did not contain information about people's past histories and daily routines to support staff in providing person centred care in accordance with the person's preferences. Despite this, people spoke positively about the care and services they received. One person told us, "There is nothing I want." The registered manager told us that they aimed to deliver care in accordance with people's wishes. She told us everyone who lived in the home had access to a family member or representative to support them in decisions about their care.

People's privacy and dignity was being maintained. People were well dressed and had been supported to maintain their personal hygiene. Staff were able to tell us how they maintained people's dignity, privacy and independence. For example, staff encouraged people to walk with their walking aids when they were able to as opposed to them using wheelchairs. Where people were able to dress themselves, even if this was partially, staff encouraged this. People told us staff respected their privacy and dignity when delivering personal care. One person told us, "I was very worried about that but it wasn't so bad."

Whilst staff knew to support people's independence, we identified this may not be happening consistently. For example, there was a member of staff assisting a person to eat some toast but we later saw the registered manager hand the person a piece of toast which they ate independently. The registered manager said the person sometimes needed assistance and sometimes did not. It was not clear how staff were determining when to assist the person.

Requires Improvement

Is the service responsive?

Our findings

People told us they had limited opportunities to offer their opinions on how they would like their care needs met. People could not recollect being involved in planning their care or seeing their care plan. The registered manager told us she carried out an assessment of people's needs prior to them coming to live at the home. She told us when people arrived she sat with them or their next of kin to devise a care plan.

People's care plans identified their care needs but they contained insufficient information to support staff in delivering person centred care. For example, a care plan in relation to personal care did not state what time the person liked to get up, whether they preferred a bath, shower or wash in bed and how often. The person's personal care plan contained no information about how they liked to dress and how staff should assist them such as supporting the person to choose their clothes. The care plan contained vague information and stated "Carers are to ensure that [person] has everything she requires close to hand, which will enable her to remain as independent as possible. Requires full guidance as to maintain her usual standards within the following (oral, nail & hair care.)" There was no information about what the person's "usual standards" were or what sort of "guidance" staff should be offering. When we asked staff about how they washed the person's hair they told us it was a struggle due to the person's deteriorating health. We could not be sure this was happening regularly. There was no information in the person's care plan about how this should be managed to ensure all of the person's personal care needs were met. Records did not state when the person's hair had been washed.

We saw the majority of people were up when we arrived at 8.10am and could not be sure this was in accordance with their choice. Three people who we spoke with told us they were encouraged to get up prior to 8am because that was when breakfast was served. These people felt obliged to be up at that time so they did not miss breakfast as opposed to them choosing to stay in bed and have their breakfast at a later time.

We noted that one person had ill-fitting dentures which were loose when they were trying to talk. A staff member told us the dentures were loose because the person had lost weight. No action had been taken to refer this person to a dentist but on bringing this to their attention they stated they would do this straight away.

People were restricted in their choices to have a bath or shower because the showers had steps which meant most people could not access them. We were told that the two showers did not get used. There was one communal bathroom with facilities to lower people into the bath if required. One person told us they were "frightened" of using the bath chair which had resulted in them not having a bath very often. Although this person's personal care needs were being met, it was not evident any action had been taken to enable them to have a choice of using an accessible shower. The registered manager agreed to speak with the provider about this.

People felt there was a lack of social stimulation and activities in the home and they would like more things to do. They told us, "We read and sleep." "I Just sit in a chair, watch TV or sleep." "We get bored there is not enough to do." Another person told us they never went out of the home but if they wanted anything such as toiletries and clothes there were "people" who visited the home and set up a shop where they could buy things. The registered manager had established links with the local church and a dance school. The dance school provided entertainment to the home at Christmas. However, people had limited opportunities to maintain other links with the local community such as visiting places of interest or visiting the shops to support the social element of their care.

Healthwatch' had visited the home in July 2015 and had made a number of recommendations for improvement within the home to help support person centred care. This included the introduction of one to one activities for people, organised outings, recruiting volunteers to help with activities and updating care plans. At the time of our visit the registered manager told us these recommendations had not been progressed to help improve the service. They told us they planned to speak with the provider about them.

We spoke with the registered manager about the range of activities undertaken. They told us some people had a newspaper delivered and we saw them reading the papers during the day. We were given an activities folder which showed there was a limited range of activities provided for people. Activities included, music, quiz, reminiscence and

Requires Improvement

Is the service responsive?

watching DVD's. It was not evident these activities were all based on people's interests, hobbies and wishes. Staff we spoke with told us activities sometimes took place but not every day. One staff member told us, "They are out of bingo stuff so they are gathering prizes." The limited range of activities meant people had limited opportunities to pursue their hobbies and interests. The registered manager acknowledged this was an area they needed to improve upon.

This was a breach of Regulation 9 HSCA (Regulation Activities) Regulations 2014 (Part 3) Person-centred care

People told us staff responded to their concerns and they felt comfortable to approach the registered manager or staff if they had any concerns or were unhappy about anything. One person told us, "There was no soap or towels in my bathroom so I went to see the staff, they sorted it out." Another person told us there had been problem with their medicines so they had spoken to the registered manager to get it resolved. However, we found that the provider's most recent complaints procedure was not easily accessible to people.

There were no complaints recorded within the complaints log held at the home. Staff told us if they received a complaint they would document it but could not say where. One staff member told us, "Luckily we don't get major complaints only about washing or things misplaced." We discussed the management of concerns and complaints with the registered manager with a view to ensuring there was a more robust system for recognising and recording these and demonstrating that actions had been taken and lessons had been learned.

Requires Improvement

Is the service well-led?

Our findings

There was an open culture in the home but processes and systems had not progressed in line with the new standards and regulations. The registered manager and many of the staff team had worked at the home for many years and they told us they worked well as a team. They told us they also shared a good working relationship with the provider. The registered manager told us the provider visited the home four times a week to carry out checks in the home. They said any areas needing attention were communicated to them verbally but there had only been "little things" for improvement that had recently been communicated to them. Records of the provider visits had not been completed to show if there had been any areas for improvement identified. We found systems and processes to assess and monitor the ongoing quality and safety of people were not in place. The provider was not available on the day of our visit or the immediate period following our visit to confirm any proposed plans for improvement at the home.

Quality monitoring systems had not been developed to drive improvement within the home. For example, there were no meetings where people and relatives could offer their opinions and views about issues related to the running of the home. People were not asked through satisfaction surveys if they were happy or unhappy about any elements of the care and services they received. The registered manager told us that being a small home, people would say if they were not happy about anything. However, this did not give people the opportunity to come together as a group to discuss their views where they could also offer their opinions about the home and also form relationships.

Staff told us they did not have staff meetings where they could share information and discuss issues relating to the running of the home. They told us that staff regularly communicated with one another so did not find it necessary to have formal meetings. As staff meetings had not taken place, there was no forum for staff and the registered manager to discuss any performance issues or changes in practice. We found copies of the current standards and legislation were not available and staff and the registered manager were not fully familiar with the new care standards so they could ensure they were implemented. Staff and the registered manager also had no computer to access the information necessary to develop standards and processes in the home to help them improve. The provider had not ensured there were systems in place to help staff in their development. Through discussions with staff we found care plans and other confidential information was being stored on a computer belonging to a member of staff who took the computer home. This meant people's personal information was not secure. The provider had not taken the necessary steps to ensure people's personal information was protected.

The system for identifying risks and risk assessment processes were not sufficient. Care plans and risk assessments were not sufficiently detailed to give staff clear direction on how to manage risks to keep people safe. For example, food and fluid charts for a person at risk of poor health were not consistently completed to show the person had consumed a sufficient amount of food and drinks. Where charts showed people had not eaten or drank much, we could not determine whether this was being identified by staff and acted upon.

Records were not always sufficient or available to show risks were being managed. Management audits had not been completed of records such as people's weight, food and fluid charts, accidents and incidents. This information was therefore not being analysed to identify any concerns and areas needing action or improvement. We identified concerns in all of these areas that required attention. For example the accident and incident forms showed a person had fallen on at least four occasions during 2015. There were instructions for staff to monitor a person at risk of falls and there was a form for staff to complete on their care file to show how often they had fallen. For this person we found that the form was blank. Staff spoken with and the registered manager were not aware of how often the person had fallen. This suggested the systems and processes for monitoring and reducing the risk of falls were not being effectively put into practice and monitored to make sure the person was not put at risk of ongoing falls and potential harm.

We observed one person had bruises on the visible parts of their body. Staff told us these had been checked by a health professional and they had advised they were due to the medicine the person was taking. However, staff could not locate records to confirm this. They could also not locate a care plan or risk assessment in regards to the bruising. This meant there were no instructions to inform

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Is the service well-led?

staff the person was prone to bruising and to instruct staff how the person should be handled to minimise bruising to their body during personal care routines. The bruises had also not been fully documented on body charts which were in the person's care file. There were no dates when they had occurred or details to show the causes had been identified to make sure they were not due to poor practice. When we spoke with staff and the registered manager about this, they confirmed this information should be in place.

When we looked at the provider's policies and procedures we found that they were not all up-to-date or accurate which meant clear guidance was not available to staff to make sure they would know what was expected of them. For example, an up-to-date complaints procedure and policy for managing abuse were not available. When we asked staff where they would record complaints they did not know but stated they would tell the registered manager. There was a risk that people's concerns may not be managed promptly and effectively if clear information was not available to staff.

This was a breach of Regulation 17 HSCA (Regulation Activities) Regulations 2014 (Part 3) Good Governance

People spoke positively about the registered manager. We asked people if they felt the home was well led, they told us, "Yes I do, the manager is very good…she seems on the ball." "Yes it is (well led) but I get fed up." "Well I've got no complaints at all." We observed that people felt at ease to approach the registered manager and makes requests of them. During our inspection the registered manager was open and honest with us about the challenges she faced within the home.

Staff were positive in their views of working at the home and there was a clear management structure so they knew who to report to. Care staff reported to the deputy manager or registered manager. Staff were made aware of the lines of reporting when they completed their induction training. The registered manager sometimes covered shifts within the home including care shifts and catering depending on when the need arose. This meant they were able to work alongside the staff team and experience any issues needing attention first hand but also meant they were not always available to carry out management duties. When we arrived at the home, the registered manager was working as part of the shift which meant she found it difficult to carry out her management duties as well as caring duties. A number of visitors who arrived at the home required the registered manager's time. An additional member of staff had not been planned to cover the staff member who was on leave to ensure the registered manager's time for management duties was protected. The registered manager however did rectify this on the day of our visit by making arrangements for an additional member of staff to come into the home. There was no dependency tool in place to show how the staffing levels for the home had been determined to make sure people's needs were consistently met.

The registered manager had completed audits of medicines to ensure these were being given as prescribed. There were also processes in place to check that staff learned from training provided by completing questionnaires. Staff told us they carried out checks on equipment such as beds when they carried out bed changes and reported any problems they found to the equipment provider. The registered manager told us she had access to a person who could complete any maintenance within the home if needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's preferences for how their care and support should be provided had not been sufficiently assessed. People had limited opportunities to be involved in decisions about their care to help support staff in meeting their needs and to maintain their wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to monitor and improve the quality and safety of services provided, were not effective. This included records not always being available or sufficiently detailed and accurate to support safe and appropriate care.