Vesta Care Homes Limited

Mount Hermon Dementia Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	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

Mount Hermon Dementia Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Mount Hermon Dementia Care home can accommodate up to 30 people and on the day of the inspection there were 25 people living there. It is on the seafront of Lancing and care is provided over two floors. The communal areas include a dining area, two lounges and an enclosed garden. There is also an activity room, in the garden.

We inspected Mount Herman Dementia Care Home on 6 and 7 September 2018. This was an unannounced inspection.

When we completed our last inspection on 27 June 2017 we found concerns relating to the safe management of medicines. Following this, the provider sent us an action plan, detailing how they would improve the key question of 'safe' to at least 'good'. At this inspection we identified further concerns, relating to the prescribing and management of medicines. There was a medicine audit in place but the actions plans were not detailed and had not led to improved practice. You can see what actions we told the provider to take at the back of the full version of this report.

The management had not ensured that standards had been improved since the last inspection. There was also a lack of oversight of the running routine management of the home. Weekly environmental checks had not been completed since July 2018, when the maintenance person left. These checks had not been passed on to another person. Similarly, when the member of staff responsible for returning the medicines to the pharmacy had left, it had not been identified that this role should be passed onto another member of staff. You can see what actions we told the provider to take at the back of the full version of this report.

There was a system of audit and quality control measures, but these had not always led to improvements in the standard of care delivered. One example, was with the management of medicines. The management team had identified that some of the action plans, relating to audits, needed to be improved and were in the process of reviewing the audit and quality assurance processes.

Staff and people told us that on occasions there were not enough staff available. There were insufficient permanent members of staff and the service were using a lot of agency staff. The management had identified this and were actively recruiting additional staff. The aim was to increase staff numbers sufficiently, to the allow for an overall increase in the number of permanent staff on each shift. The recruitment process had been reviewed and tightened up, to ensure that new staff were appropriate to work in a care setting. Before the introduction of these new standards there had been gaps in the pre-employment checks.

Staff training was not always up to date. Staff were aware of the principles of keeping people safe from abuse. However, not all staff had received their yearly update regarding safe-guarding. Staff did not always

have regular supervision. There were staff meetings but on occasions information was not passed onto staff, in a timely fashion. Some staff required additional training and support to improve the standard of care within the home.

There was an activity programme in place but this had not been tailored to individual's preferences and abilities and some people did not receive sufficient stimulation. People and their relatives had limited opportunities to provide feedback, about the care they were receiving. There was a complaints procedure, however, relatives told us they did not feel their concerns were always dealt with in a satisfactory way.

Food was prepared on site and people's hydration and nutritional needs were met. However, some people would have benefitted from additional support at meal times. People had access to health-care professionals, as necessary. There were personal risk assessments and care plans. These were person-centred and contained details about people's personal history. Methods to ensure information was accessible were considered. The staff cared for people who were nearing the end of their lives, working closely with specialist health-care professionals to ensure appropriate care was delivered. Staff used technology to help them access the care plans and record activities promptly.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice. Consent was gained from people and they were offered choices in their daily lives. People's privacy and dignity was maintained. Staff aimed to promote independence and we saw examples of compassionate care. However, people and relatives told us there was a difference between different members of the care team, with some being more supportive than others.

The home was clean and tidy. Staff took appropriate steps to reduce the risk of infection. The home had some adaptations to help people with reduced memory or poor eyesight. These included clear signage on doors and painted hand rails in the hallways.

The registered manager had recently resigned and a new manager had just started at the home. It was their third week in post at the time of the inspection. It was their intention to register with CQC as 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. Staff felt able to approach the management team with any concerns and told us they worked well as a team.

This is the third consecutive time the home has been rated Requires improvement.

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 home was not always safe.

Medication administration records did not always have all the required information, to ensure the safe administration of the medicine. The audit process had not improved standards in medicine management.

There was not always sufficient staff available. However, the management were actively recruiting new staff, with the intention of increasing staff numbers.

Staff could tell us how they kept people safe from abuse.

Weekly environmental checks had not been completed. Staff practised infection control.

Personal risk assessments were in place.

Is the service effective?

Requires Improvement

The home was not always effective.

We identified that some members of staff required additional training and support. Staff training was not always up to date. Not all staff had received regular supervision.

People were supported to eat a good diet and their nutritional and hydration needs were monitored. However, some people would have benefitted from extra support at meal times.

The home worked within the principles of the Mental Capacity Act.

People's needs were reviewed and they had access to health-care professionals, as necessary.

The home was adapted to suit the needs of different people.

Is the service caring?

Good

The home was caring.

Staff treated people with respect.

People were treated with kindness and compassion.

People's privacy and dignity was maintained.

Is the service responsive?

Requires Improvement

There was an activity programme in place but not everyone was receiving a range of meaningful activities.

There was a complaints procedure but relatives did not always feel their concerns were addressed in a timely or appropriate manner.

Care plans were person-centred and relevant.

Staff worked with specialist services to provide appropriate end of life care.

Is the service well-led?

Requires Improvement

The home was not always well-led.

There was a lack of over-sight within the home and some tasks were not allocated in a timely fashion.

There were audits and quality assurance measures in place, but action plans lacked the details required, to make and sustain improvements.

There were limited opportunities for obtaining formal feedback from people and their relatives.

There was a new manager in place and it was their intention to become the registered manager. The management team were actively seeking to improve the standard of care provided.

Mount Hermon Dementia Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 6 and 7 September 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had particular experience in caring for people living with dementia.

Before the inspection we reviewed information we held about the home. This included notifications the provider had sent to us. A notification is information about an important event the provider is required to tell us by law. We also reviewed the information the provider sent to us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spent time observing the interactions between staff and people within the communal areas and observed tow meal times and a medication round. We spoke with six people, three relatives and a visiting health care professional. We also spoke with the manager, the director of the company, the service development lead, the deputy and five care staff, the activity lead and chef. We spent time looking at records, including four staff recruitment files, care plans and assessments relating to four people, the accidents and incidents book, the maintenance records and the audit and quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

People and their relatives had mixed views about their safety. One person responded, "Yes, I feel safe here." A relative assured us, "I've never seen anything that worries me or makes me feel that she may not be treated kindly when I am not here." However, one relative questioned how safe their loved one was, commenting, "No, I'm not sure he is safe." Another commented, "It's okay, he's fed and kept clean, he couldn't look after himself at home and at least he can't go wandering off."

At the last inspection on 9 September 2017 we found concerns relating to the safe use of medicines. After the inspection the provider had completed an action plan detailing how they would ensure the safe delivery of medicines. However, at this inspection we identified ongoing concerns around the safe management of medicines.

Medicine records were not consistently in line with current guidance and best practice. We reviewed the medication administration records (MARs). Some of the prescriptions were printed by the pharmacy. Other medicines were hand-written. These were medicines that had only recently been prescribed by the GP. NICE (National Institute for Clinical Excellence) state that any new record should be checked for accuracy and signed by a second trained, and skilled, member of staff, before use. We reviewed one of these prescriptions and noted that the person's date of birth had been recorded incorrectly. The member of staff who had completed the prescription had not signed the prescription. There was also no counter-signatory present to evidence that the prescription had been checked for accuracy.
The MAR also had insufficient instructions for staff about the administration of the medicines. Two medicines were prescribed. One was a quick acting preparation, which could be given as required (PRN) whilst one was a slow release version of the same drug. There was no written instruction about how to stop one and start the other and it was apparent from the chart that standard practice had not been followed. The prescription, for one of the medicines, was also spread over three lines of the MAR sheet, and it was hard to determine what had been given and when. This could result in inadequate pain control, or the person being given too much of the medicine.

Another person was prescribed a topical medicine (a lotion or cream). On the 4 and 5 September 2018 the prescription had not been signed in the evening, and the records did not show if the medicine had been given or not. It is good practice to have a body chart to show where any topical medicines should be applied. These were missing from the person's records. The member of staff we spoke with was aware of where the medicine should be applied. However, there were a lot of new and temporary members of staff, and they may not know this information. The lack of documentation could therefore mean the medicine was not applied correctly. Medicines were stored appropriately.

There was a regular medicine audit. The last audit was in April 2018. This audit did not have outcomes or action plans. The management team informed us they had identified that more details were required on the forms, as it did not have sufficient details to effect change, or lead to an improvement in practice. The management team had also identified concerns about the ease of use of the MARs and were in the process of changing their pharmacy.

The provider had not ensured the proper and safe management of medicines. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection there were insufficient permanent staff. Some relatives expressed concerns about the staffing levels. One relative told us, "I think they are short of staff." Another stated, "Staff seem to spend a lot of time upstairs and sometimes you can wait for ages for someone to come, if you ring the bell." When asked if there was sufficient staff available one member of staff stated, "Honestly? No. Not at the moment." Another commented, "We definitely need more." Our observations supported these comments.

During the inspection there were a number of agency staff. This can impact on the continuity in care and can also affect the morale of permanent staff. The manager informed us they went through the same agency and aimed to get the same staff. One member of staff confirmed they, "generally get the same agency," but described shifts that required a lot of agency staff as, "quite tough".

A dependency tool was used to determine the level of care people required. The management team informed us that the staffing numbers had been reviewed and it had been identified that there was a need for more permanent care staff. They were actively recruiting new staff and had a number of people awaiting pre-employment checks before starting work. They were also increasing the number of staff they had overall. The management team advised us this was to enable them to increase the number of staff on each shift. They were aiming to have enough staff to cover holidays and sickness internally. The management team advised us they recognised the benefits of a stable and happy work force, with one of the them stating, "It's important to have permanent staff for continuity of care."

A system had been introduced to ensure that new staff had the relevant skills and were suitable to work within the care industry. Prospective staff had to complete an application form, submit two satisfactory references and pass an interview before starting work. There was also a Disclosure and Barring Service (DBS) check, to ensure they were suitable to work within the care industry. Reviewing the recent recruitment folders, it was clear that this process was being strictly adhered to and staff we not able to start work until all the checks had been completed.

Staff told us of the importance of keeping people safe and free from the risk of abuse. One member of staff stated, "Anytime suspicions are raised we've got to take that seriously." Another told us if they had any concerns they would, "Go straight to the manager… or go to somebody higher. The manager talked us through a recent safe-guarding. The home had followed the correct procedure and acted appropriately.

The home was in the process of recruiting a new maintenance person after the previous person had left unexpectedly in July. Since the departure of the previous employee certain regular maintenance checks had not been completed. On review of the documentation there was a list of weekly checks required. These included checking call bells and fire alarms were working and water temperatures. These were not documented as having been completed since 3 July 2018. This was discussed with the management team. They acknowledged the gaps and the new manager planned to ensure they were completed. There was a record of certificates documenting that the less frequent checks, which involved outside agencies, had been completed. These included equipment checks, for example the hoist and lift and reviews of the utilities, for example water testing and gas servicing.

Staff completed a comprehensive list of personal risk assessments. This included assessments related to people's mobility and their risk of falls, the risk of pressure damage to people's skin and an assessment of their nutritional needs. Appropriate actions were taken, on completion of the assessments, to reduce and manage the risks. There were also personal emergency evacuation plans (PEEPS). These describe the

support and equipment people require if they need to leave the building in an emergency.

There was a record for documenting accidents and incidents within the home. The documentation within this folder was variable in quality, with some entries containing more information than others. However, when asked we were told how appropriate steps were being taken to reduce the risk of future events. One example related to a person who was having repeated falls. The staff had arranged for them to have an alarm mat and crash mat to reduce the risk of injury from further falls. They had also arranged for the person to have their pain control reviewed. They explained that the person could walk more freely if they had adequate pain control and the aim was that better pain control would reduce the risk of future falls.

The premises met the needs of the people, although there were some areas within the home which required re-decoration or modernisation. The provider had purchased the adjoining house and there were plans to extend and adapt the present home. The home was clean and tidy with a good level of hygiene. One relative stated, "Generally the home is clean, I always see the cleaner around." There were personal protective equipment (PPE), such as gloves and aprons, available for staff throughout the home. The staff could talk through how they disposed of waste and the measures they took to reduce the risk of infection.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that there was a difference in the standards of care delivered by different carers. One person described the staff as, "Passably well trained," stating, "Some are better than others." Another person told us, "One or two … are a bit tricky, bossy." Some relatives also described this difference, with one saying, "The girls who wear the pink uniform are very good with him, and he takes notice of them, but some of the others don't really know what's what." This was observed during the inspection. Most of the care was seen to be given in a kind and compassionate way, with consideration of people's individual needs. However, not all staff had the same high standards and on occasions we saw some interactions, between staff and people, that suggested additional staff training and support was required. One example was a comment from one staff member, within the dining area, that we overheard. The comment did not ensure the person's dignity had been maintained. We also detected a difference in how different staff approached more challenging situations, with some being very able to diffuse potential situations but another member of staff finding it more challenging.

Staff training was not always up to date. There was a comprehensive list of training available to staff. Some of the training was compulsory. However, records indicated that some staff had not always attended this training. This included training on safe-guarding and infection control.

There was also a list of additional training available to staff. This covered other areas, which were more specific to the needs of the people under their care, for example dementia training and training about the care of people who require their food and drink in a different way. One member of staff described this course as "very interesting," and described trying thickened fluids. They commented the training, "makes you empathise with people." We discussed standards of care and training schedule with the new manager. They advised us that they were in the process of reviewing the training records, to ensure all staff received sufficient training. They also acknowledged that some of the staff required additional support, to ensure that every member of staff was delivering the same standards of care.
On the day of the inspection there was a new member of staff on duty. They were shadowing a more senior member of staff. There was a formal period of orientation and a training programme to ensure the competence of new staff before taking on the full role.

Staff did not have regular supervision. Supervision is a time for staff to meet individually with their managers. It provides one to one support and is a time for staff to raise any concerns they have. One member of staff advised us of the benefits they gained from supervision, stating, "I like getting feedback, good or bad." The management aimed for each member of staff to have supervision four times a year. One member of staff, who had been working at the home for five months, had not received supervision. Another member of staff only worked a small number of hours a week. They did not have any supervision recorded.

People were visited, by the senior staff, and their care needs assessed, before their admission to the home. One person was admitted on the day of inspection. The staff advised us that a relative had chosen the person's room. The manager had also reviewed the person in hospital, before discharge, to ensure they could accommodate their needs.

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 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 to receive the care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that there was a system in place for applying for these authorisations and for ensuring the conditions were followed.

We observed staff asking for consent and giving people choices. Staff discussed the need for people to give consent. One member of staff advised us they, "ask for consent all the time," and went on to discuss best interest decisions.

Food was made on the premises and looked appetising. One person told us, "the food is pretty good." A relative commented, "The food is lovely … I can vouch for how good it is having had it myself." People were asked what they would like for lunch in the morning. If people did not like the choice they were able to request an alternative from the chef. There was also a choice of drinks available. Some people required a pureed diet and thickened fluids. The pureed diet looked appetising and people's drinks were thickened according to their specific needs. The chef was aware of the needs of the different people. When they served the food, each plate was for an individual person, taking into account their food preferences, dietary needs and appetite.

In the dining room the meal-time was a quiet, unrushed affair. One member of staff stayed in the dining room, whilst other staff collected plates and went to help people who preferred to stay in their rooms. The member of staff who remained in the room sat between two people and helped them both to eat at the same time. This is not good practise, as the member of staff was not able to concentrate on the needs of both people at the same time. Some people would have benefitted from more personalised support within the dining hall. We observed one person taking food from another person's plate, which could have meant the other person did not have enough to eat. Another person put an excess of salt on their dinner, which could be bad for them and also mean the dinner was unappetising.

People's dietary and hydration needs were regularly reviewed and appropriate action taken. For example, one person had recently been referred to the GP as they had lost weight. The care records also specified people's food preferences. In one record it commented, "I enjoy a whisky with a mixer in the evening," and it was seen that the person did receive their drink according to their wishes.

The home referred people to health care professional and other organisations according to their needs. One visiting health-care professional told us, "They are really good at referring people onto us." One member of staff assured us, when discussing referral to other members of the health care team, "we do try to deal with needs as quickly as we can."

The home had been adapted to suit people's needs. The people within the home were living with varying degrees of dementia and there were adaptations to help people orientate themselves within the building. The toilet doors were clearly labelled with a picture of a toilet. People's rooms were identified with their names, a picture and an image of something that was important to them, for example animals or pastimes. The handrails around the home were painted red, as contrasting colours can be helpful to people with limited eyesight. We were also told that they had purchased a red toilet seat to help one particular person.

There was an enclosed garden with hand rails around the paths to improve its accessibility.

Good

Is the service caring?

Our findings

Staff were seen to be caring. We received some favourable comments from people and their relatives about the staff. One person stated, "They are really kind to me, always doing things for me. Wonderful." Another stated, "the girls are very good … they are a great help." One person told us, "Most of them are kind … Always smiling and helpful." The visiting health care professional advised us, "All of the carers are good and caring."

During the inspection we spent time observing the staff and their interactions with different people. We observed some caring and compassionate interactions. We heard one member of staff tell a person, "I like that cardigan; that's my favourite." This comment made the person smile. We also witnessed people taking time, to stop and talk, to the people they passed and delivering care in a patient and kind manner. One person asked a member of staff what they should be doing, as they walked past. The member of staff stopped and said, "I've a job to do that you can help me with." The person happily joined them to sort out some clothes.

The staff were proud of the care they provided. One staff member stated, "We put the residents first." Another advised us that the staff are, "very caring" and that, "the home is very homely." They went on to tell us, that if one of their own relatives needed care they, "wouldn't have any hesitation in them coming here." Staff placed value in getting to know the people under their care, including their individual needs and preferences. They could tell us specific details about people's life history and the things that were important to them.

People were treated with respect. The staff told us how they were treated everybody equally. This was observed in practice during the inspection. One member of staff commented, "They are a person regardless of beliefs or sexual orientation." There was also a recognition that people's needs went beyond the physical, with one member of staff telling us of the importance of seeing the whole person. This included a recognition of people's faith and the home welcomed regular visits from a local church.

People were offered choice in their daily lives. One person told us, "I choose what I want to do." Another person stated, "I like it here, I can get out and about, do what I want to do." Staff told us of the importance of providing, "A choice in how they live their lives." One described the ways they provided people with everyday choices, explaining, "I show them different outfits…let them choose," and also mentioned offering choices regarding food and activities. During the inspection we observed that people were able to wear what they preferred. We also saw that people were called by their preferred name. One person had expressed a preference for male carers. This preference was similarly respected.

People were encouraged to maintain their independence. We observed people being encouraged to continue to be independent in everyday tasks. On occasions this meant things took more time. We observed that people were not rushed and the staff did not intervene to speed things up, but were supportive of people's efforts.

People's family and visitors were made to feel welcome. One person told us, "My family visit when they can and they are always nice to them." One relative stated, "I come and see Mum and they always offer me lunch." Another relative described how they were kept informed of any changes, saying, "They do phone and let me know if there's any problems."

The staff were aware of the need to respect people's privacy and dignity. They stated "(privacy), that's a big thing," going on to mention strategies to promote privacy, for example knocking on doors before entering and ensuring people were covered up during personal care. Staff also told us about the need to preserve people's confidentiality. One stated, "We don't discuss personal care or hygiene in the corridors." Another linked this with maintaining a person's dignity stating, "I wouldn't want someone to talk about me when I am there."

Requires Improvement

Is the service responsive?

Our findings

The home offered a program of activities, but this did not meet the needs and interests of all the people living there. There was a framework for activities and there were resources and training available for the activity team. The level of activities had been raised by staff in one of the team meetings. The activity programme had since been reviewed and there were now activities planned for every day of the week. One member of staff told us, "There are more things going on for them." On the day of our inspection the activity lead was helping people with jigsaws, in one of the lounges. One person was doing a jigsaw independently, whilst another needed some prompting. There were another three people in the lounge, who were not engaged with the activity. We asked staff about the activity programme. They described how the activity team arranged group activities, for example dancing and karaoke, as well as more one to one activities. These included reading to people with limited eyesight and helping with puzzles, word searches and board games. The activity team also accompanied people on trips outside the house, including visiting the local market and library or walking along the beach to the local café.

However, some people were less able to join in the activities. One person, who was unable to go into the lounge, told us, "I get lonely sometimes, there's no one to talk to." One relative told us, "I think they should do more with him, at the last home there was always something going on and he was involved and stimulated. Here he's just left in his room all the time and you can see him going downhill." Another relative commented, "So many of them sit in the lounge with the TV on – they're not even watching it."

We asked staff if they felt there was enough activities for people. One told us, "there could definitely be more." Another us, "You can see sometimes they need more stimulation," going on to tell us, "we don't have that time to do the one to one things with them." This was echoed by another member of staff who stated, "A lot of them sit in the lounge and watch TV. There could be much more stimulation." The provision of meaningful activities, for all the people in the home, is an area that requires improvement.

People's individual needs were assessed and there were personalised care plans in place. This was written with the people and relatives. One relative told us, "I am involved in his care plan." The initial assessment included personal details, including how people liked to spend their day, details of their family and work life and things that were important to them. The information was wide ranging and specific in nature. One initial assessment included details of how the person had met their spouse and the length of time they had been married. Another stated the clothes a person liked to wear to bed and another commented, "Please allow me to wake when I am ready and bring my breakfast to my room."

The care plans were similarly wide ranging and personal and contained evidence that people were offered choice and involved in planning their care. One care plan contained details of what the person could find distressing or upsetting and strategies for reducing anxiety and promoting the person's well-being. Another listed the support a particular person required when cleaning their teeth. Staff told us they read the assessments and care plans. One stated, "there's so much in them," mentioning, people's "care needs, interests and life history."

The assessments and care plans were reviewed regularly and actions were updated. One person's recent assessments had identified they were at a higher risk of pressure damage. The staff had acted upon this assessment and had ordered a pressure relieving mattress. On the day of the inspection a new person was admitted to the home. The deputy manager was going through the documentation from the hospital and ensuring all the relevant information was captured on the assessments. Another person had been admitted the week before. They had a full set of documentation, although the home did say that learning about people's individual needs was an ongoing process.

Since August 2016 all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. The management were aware of this requirement and completed a standard for their policy folder. The staff documented people's specific requirements and we saw examples of how this was used, for example with the pictures on the toilet door. People were also referred for vision and hearing checks.

The provider offered end of life care. Staff received specific training relating to care as people approached the end of their lives. There were specific care plans relating to people's choices and any advanced decisions. As people approached the end of their life they were referred to the local palliative care team for expert support and advice on symptom management. The home worked closely with this team and completed pain assessments, to ensure people's comfort was maintained.

There was a complaints procedure, however not all concerns were addressed in an appropriate and timely manner. Two relatives gave us specific examples. We reviewed the complaints book and could not find their concerns listed. It is important to have concerns and complaints formally documented. This enables a clear action plan to be created to address the concern raised and identifies whose role it is to take particular actions. One of the concerns was raised with the management team during the inspection and they immediately initiated actions to resolve the concern raised.

The staff used a range of technology to help in care delivery. The care plans and risk assessments were completed on the computers. These could then be accessed by staff on smart phones. This meant that they had easy access to care plans. They were also able to update the daily records immediately after care was delivered, leading to a more accurate record of the care people had received.

Requires Improvement

Is the service well-led?

Our findings

The home was not always well-led. The management team had reviewed the standards of care and produced an action plan, after the home had been rated as 'requires improvement', at the last two inspections. However, the changes they had introduced had not improved the care to a good standard. There was also evidence of a lack of oversight in the general running of the home. One example was the routine maintenance checks. It was acknowledged that these had stopped, when the previous maintenance person had left. However, actions had not been taken to ensure this role was taken on by another member of staff, whilst they were recruiting a permanent replacement. Another example related to the management of medicines. A specific carer had the responsibility for ordering medicines. However, the person, who had been responsible for returning medicines to the pharmacy, had left. We asked the manager and the member of staff who was to take over the role. The member of staff observed, "I wasn't told I had to do this… there's been a breakdown in communication." The staff member concluded, "We need a meeting so that everyone's aware of that." This demonstrated that roles and responsibilities were not always considered when staff left and is an example of the lack of general oversight by the management team.

The provider had not ensured that good governance had been maintained. Therefore, the above areas are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were quality assurance measures in place, the management team had not improved standards within the home. There was a comprehensive list of policies, covering a range of topics including privacy and dignity and handling complaints. These were in the process of being reviewed and updated. There was programme of audits and quality assurance in place. This included a monthly audit by an external person, who looked at all aspects of the care and produced an independent report. The operations manager visited regularly and had oversight of the audit process. There were meetings, every three months, which involved the senior management. At this meeting the audits and quality assurance tools were reviewed, to determine what actions were required, to improve standards. A recent review had identified that not all the audits had a meaningful action plan. One example was the medicine audit. The audit had identified gaps in the medicine administration records, but did not specify actions to be taken, to reduce the likelihood of similar errors in the future. We were told the action plan was, "not robust and didn't address the issue." We were informed that the internal audit process had recently been reviewed and a new structure was being introduced. This was aimed at streamlining the process and incorporated a period of consolidation, to ensure that action plans were completed in a timely fashion.

There was a program of staff meetings. However, some staff told us they felt they would benefit from more regular meetings. One told us, "We don't have many (meetings). Maybe we should start."

There were limited opportunities for people and relatives to feedback about the care within the home. They did not have formal resident or relative meetings, although we were told they were planning to have a meeting, with relatives, in the near future. There was a yearly satisfaction survey and the last one was dated 2017. It was unclear if this meeting had led to any changes to practice.

At the time of the inspection there was a new manager in post. It was their intention to register with the CQC to become the registered manager. When we visited it was their third week in the job and they were going through a period of orientation. During this time, they were receiving additional support from the senior management team. The care staff were optimistic about the change. One told us, "I like the new manager, so far so good."

The manager was keen to be accessible to both the people within the home and the staff. They had started to attend the morning staff handover meeting. During the inspection we saw them introduce themselves to relatives and seek to be proactive in addressing concerns raised.

During the inspection we met the director. They were keen to receive feedback during the inspection and expressed determination to improve standards. The director was described as, "very approachable" and was a familiar figure to the care staff. Staff told us they felt able to approach the management team with any concerns. One stated, "If I have any issues I go straight to the managers." Staff told us that they worked well together. One member of staff commented, "We are a good team and get on well." Another advised us, "We help each other out."

The management team were keen to improve the standards of care within the home. They discussed recent research, into happiness within older people, and advised us that they were seeking to incorporate the findings into the running of the home. They went on to list their three core values, as relationships and being person-centred, teamwork and openness. They were aiming to introduce these values across the whole of the home, for example in their recruitment process. They were also planning on recognising and rewarding hard-working staff. They stated, "morale of staff really affects everything," and this scheme was aimed at making staff feel valued. There was a sense amongst the staff that standards of care were getting better. One member of staff told us, "It's definitely improving."

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the quality and safety of the service provided. Regulation 17 (1) (2) (a) (b)

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 12 HSCA RA Regulations 2014 Safe care and treatment Provider had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (g)

The enforcement action we took:

warning notice
Provider had not ensured the proper and safe management of medicines.
Regulation 12 (1) (2) (g)