

Heltcorp Limited

Goole Hall

Inspection report

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18 December 2017

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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?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on the 5 and 18 December 2017 and was unannounced.

Goole Hall is required to have a registered manager. There was a new manager in post who told us they were awaiting further checks before submitting an application for their registration with the CQC. We made checks after the inspection and evidenced the new manager had submitted an application to register with the CQC. 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.

Goole Hall 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.

Goole Hall accommodates up to 28 older people, including people who are living with dementia. On the day of the inspection there were 18 people living at the home. The premises have three floors and the lift operates between all levels. Most people have single bedrooms and 17 bedrooms have en-suite facilities. There is a communal bathroom on two floors but no shower room.

At our last inspection in November 2016, we found the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notifications of other incidents. We asked the provider to complete an action plan to show what they would do and by when. At this inspection we found the provider had implemented the actions and was no longer in breach of the two regulations.

The provider had implemented actions to ensure the home was free from odours that are offensive or unpleasant. However, the actions implemented had not been reviewed for their effectiveness and at this inspection there was an unpleasant odour in the entrance hall on both days.

The provider had failed to implement measures to prevent the spread of infection and possible contamination of people's clothing. The laundry room was not used solely for the purpose it was intended which along with the design and layout of the room meant it was not clean.

The provider had failed to ensure systems and processes that were in place to manage risks from the environment were effective. Areas of maintenance and checks around the home were not completed following the providers procedure and failed to highlight areas that required attention to keep everybody safe from harm.

People were at risk from not receiving their medicines as prescribed. Systems and processes in place to

store, manage and administer people's medicines did not always follow best practice or manufacturer's guidance.

Risks associated with people's care and support was recorded with associated support plans in place. However, these were not always robust or completed for all activities of care and support or for the environment which meant the service provided was not always safe for everybody.

We found people who used the service were not assured a quality service because there was not effective system in place to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity.

Systems and processes in place to assure the service of a skilled and supported workforce were not checked for their completeness. The provider had failed to follow their procedure to ensure care workers received regular, appropriate supervision and appraisal of their performance in their role. Provision to ensure any induction, training, learning and development needs were identified, planned for and supported were ineffective.

People were protected from avoidable harm and abuse and understood how to escalate their concerns for further investigation. The provider ensured all concerns were recorded and evaluated to help prevent re-occurrence to keep people safe.

People confirmed they received person centred care, and that staff understood the importance of maintaining their dignity and privacy. Staff discussed how they maintained people's confidentiality and when to raise any concerns.

People were supported to maintain their health and wellbeing. People had a choice at meal times and any dietary needs were recorded and catered for. The provider worked with other health professionals to ensure people's health and wellbeing was maintained.

Recruitment checks were completed which helped the provider to make safer recruiting decisions and minimise the risk of unsuitable people working with adults who may be vulnerable.

The registered provider had systems and processes to record and learn from accidents and incidents that identified trends and helped prevent re-occurrence.

Care workers had received some training in, and understood the requirements of The Mental Capacity Act 2005 and the registered provider was following this legislation.

A package of activities was provided by a dedicated activities co-ordinator. We saw activities were provided in groups, on a one to one basis and at people's individual requests. The manager discussed planned improvements and fund raising that meant people would be able to enjoy future trips away from the home.

Consultation with stakeholders and a variety of meetings helped discuss and develop areas for improvement and share information around the service.

At this inspection we found the registered provider was in breach of three regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and was rated Requires Improvement. This is the second time the service has been rated Requires Improvement.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always Safe.

Checks of the home environment and risk assessments were not always up to date or completed to ensure the home and the service people received was always safe.

Infection control was not always robust to ensure people's laundry and unpleasant odours were managed effectively.

Systems and processes were not always effective in ensuring people received their medicines as prescribed. Best practice and manufacturers guidance was not always followed.

Systems and processes in place helped to keep people safe from avoidable abuse. Staff understood how to escalate their concerns for further investigation.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Systems and processes in place had failed to ensure staff received appropriate induction, supervision and training to support them to remain competent in their role.

People were supported to remain healthy and choices of food were available. Drinks and snacks were available throughout the day.

The manager and care workers understood their responsibilities in respect of the Mental Capacity Act 2005 (MCA).

Requires Improvement ●

Is the service caring?

The service was caring.

People received care and support from staff who understood and were responsive to their needs.

People's privacy was respected by staff who understood the importance of maintaining people's dignity.

Good ●

Staff encouraged and supported people to remain independent.

Is the service responsive?

Good ●

The service was Responsive.

People had been consulted about their care and support and records included up to date information that was centred on the individual.

People were supported to enjoy activities and interests of their choosing.

The provider had information for people to follow to make a complaint and they were supported to do this if required. Any complaints were taken seriously and fully investigated.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The provider did not have effective systems and processes to continually evaluate the quality or effectiveness of the service.

The provider consulted with relevant stakeholders including people living at the home and their families about how the service was run or any improvements that could be made.

Everybody spoke positively about the new manager and staff at the home.

Goole Hall

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 was a comprehensive inspection. This inspection took place on the 5 and 18 December 2017 and was unannounced.

The inspection team consisted of one inspector and an expert-by-experience on the 5 December 2017 and one inspector on the 18 December 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older people and dementia care.

Before the inspection, we contacted the local authority who provided their feedback. We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service.

We asked the provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

We spoke with four people who used the service and two of their relative's. We spoke with the manager, the activities co-ordinator and five care workers.

We observed interactions between people and staff in the communal areas, during activities, and during mealtimes. We looked at how the provider managed and administered people's medicines and observed the lunchtime medicines round.

We spent time looking at records associated with the running and management of the home. We looked at individual care records for three people who lived there and we looked at records on file for four care workers.

Is the service safe?

Our findings

At our last inspection in November 2016, the provider had failed to ensure all areas of the premises and equipment used were clean or suitable for the purpose for which it was being used. This was a breach of Regulation 15 Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan, and during this inspection we checked and found that improvements had been made and the provider was compliant with this regulation.

During this inspection, we checked and found the provider had failed to ensure people's medicines were managed safely in line with manufacturers and national guidance or that they were always administered as prescribed. We found storage for people's medicines was not in a dedicated medicines room but in cupboards in a communal area. Cabinets used for storage were locked however; keys were kept in an unlocked drawer with no procedure in place to ensure all medicines were stored securely with access restricted to only those who required it. A fridge was used to store people's medicines and temperatures recorded following manufacturer's guidance. All other medication should be stored below 25°C. However, temperatures in the room were not recorded. This meant the provider was unable to assure that people's medicines were kept at the required temperature. If stored at the wrong temperature, medicines may not work in the way they were intended and therefore may pose a potential risk to the health and wellbeing of the person receiving the medicine.

We could not be assured people had received their medicines in line with the prescribing instructions which meant they were at risk of harm. We looked at Medicine Administration Records (MAR's) for three people and found some errors of recording, and remaining stock did not always balance. Where staff had initialled the MAR, the provider did not hold a signature list to ensure when checks were completed, that only care workers deemed competent to administer medicines had signed the MARs. A visitor told us they were concerned as the provider had failed to administer medicines for their relative because the home had run out. We asked the manager about this and they told us it was due to the pharmacy having a delay in delivery. We were concerned as the pharmacy is based in Castleford which is in West Yorkshire. The manager told us this was under review.

We observed best practice was not always followed when staff administered and recorded people's medicines. We observed a staff member administering eye drops without the use of personal protective equipment (PPE) which meant the person was at risk of infection. We found that people's medicines were recorded after they had been observed taking them. However where people received their medicines from a patch, the provider failed to follow the manufacturers guidance and implement a record of placement for example a body map. This put the person at risk of receiving medicines without appropriate guidance in place.

The provider had a policy and procedure to ensure medicines were managed and administered safely. However, the manager confirmed the policy was not up to date and did not directly reference sources of best practice. For example, by 'The National Institute for Health and Care Excellence' (NICE). The manager investigated the concerns we raised and commenced implementation of the required changes during our

inspection.

People were not always safe from avoidable harm because the provider had failed to always implement actions where concerns were highlighted. A fire risk assessment had been completed on 14 July 2017. The assessment included actions that we found had not been completed to keep people safe in the event of a fire. For example, the report recorded a fire extinguisher in the laundry room 'should be taken out of service, replaced or serviced.' We checked and found the faulty extinguisher was still in place.

A system and process was in place to check water quality throughout the home to help prevent Legionella which is a waterborne virus, and to avoid scalding. This included weekly and monthly water temperature checks. We found these had not been completed as required by the provider and were out of date. Monthly checks had not been completed since 23 May 2017 and weekly tests since 16 October 2017 which meant the provider had failed to follow their own guidance to control the associated risks. This meant people were at risk of harm.

We saw checks had been completed on mattresses and equipment used for the moving and handling of people. However, where bed rails were in place the provider had failed to implement maintenance checks on their operation and safety. The manager told us they would review and implement national guidance, provided by the Health and Safety Executive to ensure staff were appropriately trained in the use and management of bed rails and that they were safe for the people who used them.

At our previous inspection we noted an underlying odour in the entrance hall and some communal areas. The manager told us the provider had removed some carpeting and had polished the stone floor area. At this inspection we noted improvements in the communal areas. However, there was still an unpleasant odour in the entrance hall on both days. This meant the actions implemented had failed to ensure the home was free from odours that are offensive or unpleasant.

The laundry area was not fit for the purpose it was being used. Checks had failed to ensure the room remained free from non-laundry items which posed a risk of contamination and cross infection of people's clothing. Items stored in the room included decorating materials in and around the sink area. People were at risk from items stored in the laundry room including cleaning chemicals because the provider had failed to ensure the room was signed and locked to prevent access. We discussed our concerns with a senior care worker who arranged for the area to be tidied up. However, during the next inspection day we observed the sink area had again been used to clean DIY equipment. The manager told us the provider had plans to re-design and tile the room to ensure it was suitable for the purpose it was being used.

Because of the above concerns, the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 Safe care and treatment.

Despite our concerns people told us they felt safe in their home and with the support they received. Comments included, "I do feel safe living here; no complaints" and "Yes, I need so much help, my left leg keeps giving problems and then I can't stand on it. Staff help me to feel safe, I can call them if I need help."

People living in the home were kept safe from abuse. Staff had received some training in and understood the importance and procedures to safeguard people from avoidable abuse. They told us, "I haven't had any training for a while, but I am clear of the types and signs of abuse to look out for and I wouldn't hesitate to report any concerns for investigation." "I completed whistleblowing training in my last job. I would always share any concerns if I observed bad practice it is our duty." The provider enforced a zero tolerance of abuse in any form. The manager showed us a policy and procedure they had in place to ensure any safeguarding

concerns were recorded and fully investigated. The policy included contact information for the local authority safeguarding team. Where incidents had been recorded we saw these were appropriately referred to the local authority and investigated.

The provider had completed risk assessments to ensure people received safe care and treatment. We saw risk assessments for pressure area care, skin integrity, diabetes, falls, mobility, aggression and agitation and nutrition. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date. When people were at risk of developing pressure sores, we saw that they had been provided with the appropriate equipment to minimise this risk. People also had regular positional changes to help relieve pressure on certain areas of their body. A health care worker said, "Pressure care is very good and the provider is responsive to any advice we might provide."

During our inspection, there were sufficient numbers of staff on duty to meet people's individual needs. The manager told us they evaluated the rotas to ensure the service had the required skilled mix of staff. The manager said, "We can rely on support from off duty staff and have adverts out for recruitment. We are implementing a dependency tool which will assist us in ensuring we have sufficient staff on duty in particular where people's needs diminish and to meet with any increase in the number of people living here."

The provider had completed pre-employment checks which helped ensure staff were of suitable character to work with people who may be vulnerable. This included checks with previous employers, where we saw references had been obtained and recorded, and checks with the Disclosure and Barring Service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands and can help employers make safer recruitment decisions. Staff had completed application forms, interviews and health checks which ensured they were fit and healthy and understood the expectations of their role.

Accidents and incidents were appropriately managed and recorded by the provider. Up-to-date and accurate records were maintained to ensure accountability and to help reduce the level of accidents and incidents across the service.

Is the service effective?

Our findings

The provider had failed to follow and complete systems and processes to ensure staff received appropriate induction to their role and the home. We checked with the provider and found six staff had commenced employment at the home in 2017. The provider had recorded the six employees had completed an induction programme. However, we were unable to evidence further certification of completion of an induction for those members of staff. Staff we spoke with provided mixed feedback when asked if they had completed an induction to the home and associated training before they commenced their duties with people. Comments included, "I started this year and completed some shadowing of a member of staff for about six hours. It mainly involved getting people up and ready." "I started this year; I have not completed any training here. I have experience in care work but have not been asked for my certificates." "I have worked here before; I was shown around the home but nothing more. I haven't completed any training but there is some now planned in for next year." This meant the provider had failed to ensure that where new care workers had been employed that they had followed an induction programme similar to the Care Certificate standards to make sure they were supported, skilled and assessed as competent to carry out their roles. The Care Certificate is a set of standards that social care and health workers follow in their daily working life as recommended by Skills for Care, a national provider of accreditation in training.

This provider had failed to assure themselves of an appropriately trained workforce to meet the needs of everybody living in the home. The provider recorded training due, planned and completed on an electronic matrix. The matrix identified no further training had been completed in areas the provider considered mandatory for the six new employees who commenced their role in 2017. This included but was not limited to moving and handling, first aid, health and safety, infection control, fire safety, food hygiene and safeguarding. We spoke with the manager about this who told us that training had not been kept up to date by the previous manager. They told us about some training they had planned in for staff and this included dementia care and the Mental Capacity Act.

The provider had failed to ensure care workers were supported in their role following their own procedure. We checked supervision and appraisal records for four staff and found two had received supervisions in 2017. Care workers who we spoke with told us, "I had one supervision since May this year; nothing else but they are being planned in now." "It is getting better now with the new manager; I have some training in end of life care planned." The manager showed us a matrix with planned supervisions in place for 2018. They told us supervisions had been irregular under the previous manager.

New staff had not been appropriately inducted and their competency to provide safe and effective care had not been assessed. This meant the provider could not be assured staff were providing people with a high standard of care. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18: Staffing.

During the first day of this inspection, we observed people were disorientated by the lack of appropriate signage in particular for those people living with dementia. One person who showed signs of confusion said, "I don't know where my room is or where I am." The home was undergoing some renovations and because

of this we were told signage had been removed. This included numbers to identify people's rooms. We discussed this with the manager who arranged for the numbers to be re-instated and this had been completed by our second visit.

There was some outside access and a care worker showed us an area of garden that was used by people in the summer time. People were able to navigate between rooms and floors using the passenger lift which was wide enough for wheel chair access and for those with walking equipment. One person said, "I walk badly, staff have to take me as I go in the lift, being upstairs you're a bit out of the way." Another person told us, "I don't know the home all the way around, I walk up the stairs by myself and I will go in the lift if there's someone already there." The provider had installed shop fronts and cleaned up the solid flooring in the main entrance. This provided a simulated shopping street with café tables where people could spend their time."

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

We looked at training records for care workers, we found completion of specific MCA training was planned but had not been recorded as completed for all care workers. However, the manager and care workers had a good understanding of the MCA and knew when to apply the Act and when to follow the requirements of a DoLS. A care worker said, "I always encourage people's independence and offer choices even if they have a DoLS in place." Another care worker said, "We are here to support people and this is their home; I would always respect their wishes and offer them choices in whatever we are doing." Care plans we looked at included a capacity assessment completed by the registered provider. Where people were assessed as not having capacity, applications had been submitted to the local authority for further assessment and approval of a DoLS.

Our observations confirmed that staff asked people for consent before they assisted them with any aspect of their care. Where people were able to consent to care and support we saw this was recorded in their care plan. Where best interest meetings were recorded these included consent from representatives appointed with Lasting Power of Attorney (LPOA). A LPOA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. We saw this information was recorded in people's care plans. The manager told us further work was planned to ensure care plans accurately recorded where a LPOA had been validated and the scope of the appointee to make decisions on behalf of the person.

The provider had regular contact with health and social care professionals to discuss any concerns about people's physical or emotional health. These contacts were recorded in people's care plans. People confirmed they could see a doctor when they needed to. Comments included, "I haven't seen doctor for a time. They (the optician) come here; I had my eyes tested and got 2 pairs of glasses." "I ask if I need a GP, they do it quickly here but the rest depends on when the GP can come out. The chiropodist, dentist and optician come in regularly but I have them in town and I go out to them, they arrange transport and a carer comes with me."

The provider ensured information was available to ensure they received consistent care and support should

they need to visit other health services for example a hospital. The provider had completed hospital passports which were personalised to the individual and included details of their health needs, any religious preferences, diets, things the person liked and details of other people who help the individual.

The provider ensured people received food and dietary support to help them remain healthy. Where people had any particular dietary requirements for example, due to diabetes or by choice such as vegetarian or vegan, information was recorded in their care plans and the provider ensured their needs were met. Where people had difficulty swallowing the provider ensured they sought additional guidance and support from appropriate health professionals to ensure they maintained a healthy diet. One person had received a visit by a speech and language therapist (SALT) and as a result of the guidance provided we observed the person's food was pureed and they received direct assistance from staff at meal times.

Where people required special cutlery and crockery to help them with their food this was provided. Staff readily recognised who required assistance and this was given in a friendly and polite manner. People were offered hot and cold drinks and snacks throughout the day. There was a large dining room downstairs and people could also eat where they choose to, including their own rooms. There was a menu on display with details of the ingredients for the meals which set out any allergens contained in the food. A care worker told us the menu was also displayed on an easel in the main entrance area. People were offered a choice and this included a desert.

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff cared about them. One person said, "Yes, I find them very nice and caring." Another said, "They are helpful and very hardworking."

We observed everybody working at the home had a good positive caring relationship with people who lived there. Everybody knew each other and staff had a clear understanding of the best way to support each person with their individual needs. Where one person showed signs of confusion and distress we observed a care worker was attentive and reassured the person. They showed compassion and assisted the person to regain composure in an unhurried manner.

People were clearly relaxed throughout the day and staff were available to support them when this was required. Where people remained in their rooms they had access to a call bell which they used to alert staff that they required assistance. This was often heard during our inspection and responded to in a timely manner. One person said, "I pressed the buzzer once in the middle of the night as I'd got out of bed to use the commode, they (staff) were here very quickly."

Care plans recorded people's preferences. We saw information included the preferred name people liked to be called and we saw that these were used by staff. Peoples preferences for any particular gender of care worker was discussed and where specified this was recorded in their care plans. We observed that staff respected privacy by knocking on doors and asking for permission before entering the room. One person confirmed, "Yes, they always knock, unless they've got their hands full, then they bump the door to let you know they're coming in."

Staff understood the importance of treating people compassionately and respecting their privacy and dignity. A care worker said, "When providing personal care such as bathing I would always encourage the person to assist with anything they were capable of. I would use towels and close doors and would ensure they had some privacy on their own, as long as it was safe for them to do so." Another care worker said, "People can choose when they want to have a bath or wash; it doesn't matter what time of day it is; it's their choice." There were two bathrooms at the home but no shower. People said, "I asked them to give me a good wash this morning and always feel very comfortable; no complaints." "I can wash myself but have to have help with a bath. I never feel embarrassed, there's usually a towel to put around if you need it and they help you with the areas you can't reach."

People in the home told us they received their care and support from regular staff. Comments included, "Yes, I do know them, at night there's only two of them on duty." "Some of the young ones don't stay very long and you don't get to know them well. I know all of them but can't always put names to them."

Care plans included information that ensured people were communicated with and received information that was easy to understand. Where people had difficulty with speech or hearing this was recorded and staff confirmed they knew to be patient and speak clearly with those people. We observed staff were aware of people who had hearing and sight problems. People were supported and encouraged to wear their

spectacles and hearing aids.

People we spoke with told us family and friends were always made welcome. They said, "[Name] visits whenever they want to. They try to avoid dinner time as that's a busy period." The manager confirmed there were no restrictions on visitors to people living at the home. A relative said, "They always ring me if there is a problem and will tell me about anything when I come in. I visit 2 to 3 times a week."

Information about advocacy support was available around the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Confidential information and records was held securely and only accessible to those people who were required to do so. Staff recognised the need to maintain people's confidentiality. A care worker said, "Discussions we have are private and not to be shared. Unless the concerns involved health needs or safeguarding concerns then I wouldn't discuss anything with anybody else."

Some staff had completed training in equality and diversity. We were told that people from all backgrounds were welcome at the service and that steps were taken to ensure that all people were treated with dignity, respect and without discrimination. The provider ensured people's personal beliefs were supported and this was recorded when people completed their initial assessment to live at the home.

Is the service responsive?

Our findings

Everybody living at the home had a care plan in place. Before people moved into the home their needs were assessed to ensure the service was suitable for them. It was clear from those records that they or their nominated representative had been consulted with and their wishes and preferences recorded. This included their preferred routines of care and how they communicated their support needs. Records we looked at had been signed by the person where they had capacity to do so to confirm their acceptance and agreement to the content. Where people did not have capacity best interest decisions had been made that included a person's legally appointed representative and advocate where this was required.

Care plans were centred on the individual, detailed records included any specific personal preferences for example, gender choice of care workers, religious, food, sexual preferences and health needs. People were supported to maintain loving relationships and partnerships were evidenced between individuals who had got to know each other whilst living at the home. A care worker said, "We don't judge people; this is their home and we respect that. Some residents enjoy each other's company and spend time in each other's rooms. If they have happy relationships then that's a positive outcome." A hairdresser attends the home every Tuesday. One person said, "I look forward to having my hair done." We observed positive interactions between the hairdresser and people at the home. After the hairdresser had finished for the day they spent some time in the lounge chatting with people. As part of the renovations a dedicated room was being developed as a hairdressing salon for people to use.

Information was also recorded that ensured the person's abilities, wishes and preferences were recorded for daily activities of care and support. Examples included washing and dressing, hair care, foot care, sight, tissue viability, history of falls, and continence. Information recorded the type of support and how much the person could do independently. Assessments of need were rated and evaluated monthly. When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk. This meant staff had access to current information that was up to date and reflective of the person's needs. They were able to provide person centred care without undue restrictions in place.

Where people had chosen to, their end of life care wishes and any advance decisions were documented in their care plans and kept under review. However, information in one care plan we looked at contained conflicting information. The person had an advanced decision for care and support but this had not been updated in the key information document. This was investigated and updated during our inspection. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate. The manager told us this was a sensitive subject to discuss with people and their relatives but that they were pro-active in recording people's wishes.

Care records included information on people's interests and hobbies. People were provided with choices. People said, "I can pretty much do as I like; I have only my own limitations." "I generally watch television. I used to play bingo but I prefer to just chat with [name of activities coordinator]."

The home had the provision of an activities coordinator for 12 hours a week, spread across Monday, Wednesday and Friday. At other times staff arranged activities. On the afternoon of our inspection, staff organised a game of passing the ball and skittles in the lounge which was enjoyed by those people who participated. Staff interacted well with people and there was laughter and a general feeling of 'community' during this event. The activities co-ordinator told us, "Bingo is their favourite and we do reminiscence quite a lot as they love it. Sometimes we do art and crafts but not everybody is able to join in so we do fun things like i-spy and dominoes. We make birthday and Christmas cards which we sell to staff and families and the money goes into the resident's fund"

A notice board in the home detailed a variety of planned activities for the week ahead. Brief details of involvement and outcomes for people was recorded and evaluated. We saw activities provided included both group and one to one support. The manager told us about a Christmas event that had included food and entertainment and had raised further money for the residents' fund. The manager said, "Previously people have not been able to go out on day trips due to insufficient funding. Since I have been in post we are raising funds to make day trips out a reality in particular when the weather starts to improve a bit." They told us they had ordered 'twiddle blankets' for those people with dementia. Twiddle blankets are usually knitted with items attached to keep dementia patients' hands active and busy.

The activity co-ordinator told us they tried to forge links with the community. They said, "Some local school children came in and sang last Christmas and we are hoping to do the same this year. It is something we are hoping to build on."

People and their relatives we spoke with told us, should they have cause to, they would be happy to raise a complaint. A relative said, "I complained about my relatives window; it wouldn't open properly but it is better now." One person told us, "I wouldn't complain unless I needed to but if I did I would tell them and I'd mention it to one of the senior carers or the manger". A care worker said, "Some people might not be able to complain. We would be able to identify from their expressions and body language if something wasn't right. We would talk with them and encourage them to address any concerns they might have." The provider had an accessible complaints policy and procedure. Where complaints had been received they were recorded with outcomes. The provider had followed duty of candour and had responded to individual complainants with any outcomes. There was also a record of compliments and thank you cards from people and relatives expressing gratitude for the care provided by the service.

Is the service well-led?

Our findings

At our last inspection, which we completed in November 2016, we found the provider had not informed the Care Quality Commission (CQC) when DoLS applications had been approved. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notifications of other incidents. We wrote to the provider about this. During this inspection we checked and found the provider had submitted and continued to submit the required notifications and were no longer in breach of this regulation.

During our inspection we found the provider had failed to continually check and evaluate their governance and auditing practice to ensure systems and processes that were in place to meet with all regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were robustly followed and completed to uphold the required standards of care.

Processes were in place to complete health and safety checks. However, the provider had failed to ensure these were completed in line with their procedure. Lack of oversight had resulted in areas of maintenance not being identified on the associated action plan or completed in a timely manner.

The provider had implemented a maintenance file and a daily maintenance log was available for completion. However, there was a lack of oversight at provider level to ensure this information was maintained because we found checks had failed to highlight all the areas of maintenance requiring attention. The manager was responsive when we raised these concerns and some remedial actions were implemented during our inspection. However, we found checks were ineffective and had failed to highlight and remedy possible risks. This included a broken tap in the communal toilet area, a broken handle to the fridge door in the kitchen and no outside lights to navigate the unlit entrance to the home; which meant everybody was at risk from trips and falls.

At our previous inspection we received feedback that because the driveway had pot holes, it was not always safe to navigate. The provider had assured us the driveway received regular maintenance and that the use of chippings would be continued. However we found there was a lack of oversight at provider level to ensure the daily checks on the drive way were completed. We found these had not been completed since the 27 November 2017. At this inspection we observed the driveway had an uneven surface and we were again informed by staff that it was not always safe to navigate and was in need of further improvement.

Quality assurance checks including audits failed to identify and remedy other areas of concern that may affect people's wellbeing and the quality of the service provided. For example, we found the central heating boiler inspection record had not been completed following the providers guidance and checks to ensure the safe use and condition of mattresses had not been completed. Water temperature checks to help prevent scalding and Legionella virus had not been maintained and information was out of date. The provider had failed to ensure quality assurance checks included systems and processes to ensure bed rails were checked for safe operation and use following national guidance.

Where external contractors had been used to assess the fire system in July 2017, associated actions were still outstanding. Improvements to the laundry room were required and had not been implemented or completed within a timescale that reflects the level of risk and impact on people using the service.

Systems and processes in place to ensure records were updated and maintained relating to people employed were ineffective. Because of this lack of oversight the provider failed to implement effective checks to assure themselves of a skilled and supported workforce.

The provider had failed to regularly review systems and processes including audits that were in place and completed to check that people received their medicines as prescribed and that medicines management followed national guidance and guidance from the drug manufacturers.

The concerns we found during this inspection were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 Good Governance.

The new manager was responsive to all of the concerns we raised. During the inspection they addressed some of the concerns we had raised and implemented an action plan. They told us, "We have taken steps to ensure the maintenance programme is improved." We are working hard to improve care plans, training and supervisions and have those planned in for the New Year."

The home was required to have a registered manager in post. There was a new manager in post who told us they were awaiting further checks before submitting an application for their registration with the CQC. We made checks after the inspection and evidenced the new manager had submitted an application to register with the CQC.

Everyone we spoke with at the home knew the name of the manager. We were told and we observed the manager had an 'open door' policy and was always approachable. One person said, "I know her name is [name], I see her at least daily, I think she makes a point of seeing everyone every day. She's not been here long; she's very nice, down to earth. Staff said, "The new manager is great, things have already started to improve and I feel like I am part of a team again." "Everything is improving, we are re-implementing and improving some old ways of working; the new manager can see the positive and what works." A health professional told us, "The service is certainly improving; the new manager must be having a positive impact."

There was clear staffing structure and staff at all levels had a clear understanding of their roles and when to escalate any concerns for higher level investigation. Staff told us they enjoyed their role and working at the home. They told us, "People are well supported and we all work together to ensure they have a good quality of life." "It's much better with the new manager; staff are happier which has resulted in happier people." People told us they liked living at the home. They said, "Yes, I just like it, quite happy with the place." "If I can't be at home then yes, I wouldn't go anywhere else."

The provider had sought the views and feedback from people who lived at the home and their relatives via a survey sent out in November 2016. 17 people had responded which had included requests to improve the décor. The manager told us this was part of the renovation programme at the home and people were informed of this as part of the recorded residents meetings. The manager told us this ensured feedback was received on a more regular basis and that they were able to identify and resolve any areas of concern without undue delay. This meant the provider sought and acted on feedback to help maintain and improve standards of care and support.

The manager who was new in post told us they kept up to date with best practice by attending local authority steering groups and care sector forums as well as seeking on line guidance and receiving information sharing from the provider's other services.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not always provided in a safe way for service users. Associated risks to the home environment and people's care and support had not always been completed or were up to date.</p> <p>People's medicines were not always managed and administered as prescribed following manufacturers and best practice guidance.</p> <p>Regulation 12 (1) (2)(a)(b)(d)(e)(f)(g)(h)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider failed to ensure staff received such appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.</p> <p>Regulation 18 (2)(a)</p>

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not have effective systems and processes to continually evaluate the quality or effectiveness of the service.</p> <p>Regulation 17 (2) (a)(b)</p>

The enforcement action we took:

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