Akari Care Limited

Wellburn House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 4 and 5 June 2018 and the first day of the inspection was unannounced.

We last inspected the service in October 2017. Following this inspection the service was rated 'requires improvement' and we identified breaches in two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we had concerns about the safe management of medicines and the lack of effective auditing.

Following the inspection in October 2017 we served a warning notice against the registered provider in respect of the breach in regulation 12, safe care and treatment. This was because of concerns we had regarding the safe management of medicines. The warning notice stated that they must take necessary action to comply with this regulation by 31 January 2018.

We also issued a requirement notice in respect of the breach in regulation 17, good governance. This was because the provider did not have an effective system of audits in place and they were not identifying the issues we found during the inspection. The registered provider sent us an action plan detailing how and when they would take action in order to meet this requirement notice. The action plan stated that all of the work necessary to become compliant with this regulation would be completed by the end of November 2017.

During this inspection we found some improvements had been made but there were still areas of concern and the service remained in breach of these regulations.

Wellburn House 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.

Wellburn House can accommodate up to 90 people across three separate areas in a two storey building. One area, Laurel, provides residential care and the other two areas, Lilac and Fern, provide care to people living with dementia. Lilac is on the ground floor whilst Fern is on the first floor and provides care for people who have higher level care needs due to the advanced stage of their dementia. At the time of our inspection there were 45 people living at the service.

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

This is the fifth time the service has been rated Requires Improvement since September 2015. In June 2016 the service was rated Inadequate.

There was still no robust system of audits in place. Those audits that were taking place were not effective as they did not identify all of the issues we found during the inspection. When audits were completed action was not always taken to make the necessary improvements. Quality assurance surveys were conducted but there was no clear action plan produced as a result of feedback.

Records were not always up to date, accurate or complete.

Medicines were not always managed safely for people. Improvements still need to be made in guidance and records for 'when required medicines' and topical medicines.

Risks assessment tools were not always used correctly. Some people did not have risk assessments in place to provide staff with information on how to manage and minimise all identified risks.

The provider had calculated the number of staff needed to safely meet the needs of the people using the service. We saw that the staffing levels were in line with these calculations however we received feedback from staff and relatives that people sometimes had to wait for assistance. We have made a recommendation about this.

Checks were carried out around the service to ensure the premises and equipment were safe to use. Staff had not always responded promptly during fire drills but no action had been taken to address this.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

Staff had knowledge of safeguarding and were aware of the action to take if they had concerns.

Staff had not completed all of the training the provider had identified as essential. There were a number of gaps in the training record and a number of staff were overdue refresher training. We had made a recommendation about this following our inspection in October 2017 however the issue had not been resolved and as a result the provider was now in breach of regulation.

New staff underwent a seven day induction but the induction did not include completion of the Care Certificate. We have made a recommendation about this.

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 service supported this practice.

People were supported to maintain a healthy diet, and any special dietary needs were catered for. However, there were no picture menus in dining rooms and although people were offered choice this was done in a way that was not suitable for those living with a dementia.

One area of the service had been decorated in a dementia friendly way however a second area for people living with dementia had been recently created and did not have similar dementia friendly décor. We have made a recommendation about this.

We saw evidence in care plans to show the service worked with external healthcare professionals to maintain people's health.

Staff spoke to people kindly and patiently and we observed friendly interaction between people and staff.

We were told that one person was using an advocate but there was no evidence of this in their records. There was no information on display to help people access an advocate should they wish to.

We saw the complaints were investigated but this was not always in line with the provider's complaint's policy. The records relating to complaints were not clear or well organised.

Staff had an understanding of people's needs and how they liked to be supported but this was not always reflected in detail within care plans. Some care plans contained generic information and some plans appeared to be cut and paste documents as they referred to people by the wrong name or gender.

People, relatives and staff felt the registered manager was approachable and supportive.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely for people.

Risk assessments were not always in place, up to date or accurate.

Poor staff response during fire drills had not been addressed.

At times people had to wait for assistance from staff as there were not always two staff available to provide the necessary support.

Appropriate checks had been undertaken before staff began work.

Is the service effective?

Requires Improvement

The service was not always effective.

Essential staff training was not complete or up to date.

People nutritional needs were met but the way choice was being offered was not best practice for people living with dementia.

DoLS authorisations were appropriately applied for and kept up to date. Some mental capacity assessments were not decision specific.

Some areas of the building had been adapted to be dementia friendly but this was not reflected in all areas where people with dementia were living.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst we found the staff team kind and caring in their approach to supporting people, the provider was not ensuring the service was caring overall.

People were treated with dignity and their privacy was protected.

People were encouraged to maintain relationships with friends and family with visitors made welcome throughout the day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans contained detailed personal information. Other care plans were more generic and some contained inaccurate details.

People's end of life care plans did not always reflect information within their advance care plans.

There were some activities taking place within the service although there was no information provided about upcoming events.

Complaints were investigated but clear records were not kept and formal acknowledgement was not sent in line with the provider's complaints policy.

Is the service well-led?

Inadequate

The service was not well led.

The provider and registered manager had failed to ensure that the service met the requirements of the warning notice issued following our last inspection. They had also failed to fulfil the action plan sent to us.

There was no effective system of audits in place.

Records were not up to date, accurate or complete.

There was no evidence of how information from quality assurance surveys was being used to drive improvement in the service.

Wellburn House

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 4 and 5 June 2018 and the first day was unannounced.

The inspection team consisted of one adult social care inspector, an inspection manager and a pharmacist inspector.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We used information the provider sent us in the Provider Information Return. 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 also contacted the local authority commissioners for the service, the local authority safeguarding team and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with six people who lived at the service and four relatives. We looked at five care plans and medicine administration records (MARs) or aspects of medicine management for eleven residents across the home. We spoke with eleven members of staff, including the registered manager, the regional manager, care staff, activities co-ordinator, domestic staff and kitchen staff. We looked at five staff files, including recruitment records.

We also spoke with a visiting health professional and completed observations around the service.

Requires Improvement

Is the service safe?

Our findings

At our inspection of Wellburn House in October 2017 we found that administration records did not provide a clear picture of all medicines a person had taken or the reasons why they had not. There was no guidance or records in place for some topical medicines such as creams and ointments. Topical medicines records that were in place were not always fully completed. Staff had not applied some creams at the frequency prescribed. There were incomplete patch application records in place for those people who received medicines via this route. Records and guidance for medicines that were prescribed to be taken 'when required' were not satisfactory. There was insufficient information to ensure people who were unable to give consent and were given their medicines covertly received them safely and consistently. This was a beach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we looked at how medicines were handled and found that the arrangements were not always safe. We saw some improvements since our last inspections however further improvements were still needed to be made in the records and guidance for topical and when required medicines.

We found the administration of people's prescribed oral medicines were clearly recorded, however where non-administration codes were used, the reason for not giving medicines was not always clear. Where care staff applied creams as part of personal care the guidance on the frequency of application or where to apply was incomplete or missing. Some records were not fully completed or could not be found and some creams had not been applied at the frequency prescribed. Two creams for two people had been applied regularly from the MAR; however, this was not reflected in the amount of cream used. This meant we could not be sure that people's prescribed creams and ointments were used as prescribed.

Instructions for some people receiving medicines 'when required' were missing. This information is important to ensure staff are aware of the circumstances under which these medicines should be given. For one person the maximum dose on the guidance was incorrect. For another person prescribed a medicine for agitation the when required guidance stated that the dose was half a tablet, however one tablet was administered on two occasions with no documented explanation. In addition, we found staff did not always record the reason for giving the medicine or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. One person was regularly administered a when required medicine to help them sleep, however there was no evidence of review or any guidance for use in place and their sleep care plan contained no reference to this medicine. The failure to have clear guidance and keep accurate records increases the risk of declining health and wellbeing.

We looked at records for one resident who had a plan in place to receive their medicines covertly, hidden in food or drink. There was documentation showing this had been agreed with a review date of February 2018; however, we were told by staff that this had not been reviewed as specified in February. In addition, three medicines listed on the MAR were not included in this assessment and there was no record of input from a pharmacist to advise the home how to disguise these medicines if needed without reducing their effectiveness. Care staff said that this person was now compliant with medication but the covert plan was still in place and had not been reviewed and no changes in compliance were documented.

We looked at how medicines were stored. Staff kept records of room and fridge temperature, however we found that on one unit the maximum fridge temperature had exceeded the recommended temperature on three occasions in May 2018 and the whole of April 2018 with no action taken. Care staff were unsure what the maximum should be and what action to take when the temperature fell outside the recommended range, they were also unsure how to reset the reading after the temperature had been noted. Therefore, we could not be sure these medicines were safe to use.

For medicines administered as a patch, a system was in place for recording the site of application. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered. Eye drops, which have a short shelf life once opened, were marked with the date of opening. This means that the home could confirm that they were safe to use.

We looked at the individual risk assessments in place for people who used the service. Although some risk assessments were present we saw this was not the case for all identified risks. For example, one person was at risk of choking but a corresponding risk assessment and plan of care had not been put in place. Other risk assessments we looked at were not up to date and some risk level calculations were inaccurate. For example, we looked at how recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used. We found that inaccurate information had been entered into the tables or calculations had been done incorrectly and this impacted on the identified level of risk. Risk assessments were scheduled to be reviewed on a monthly basis but this was not happening in every case. This meant the records may not reflect people's current needs.

We saw that fire drills were being conducted but no action was being taken to address poor staff response. For example, the record for a drill carried out on 9 February 2018 stated the response time of staff was eight minutes. On 15 May 2018 this was recorded at five minutes and this was marked as 'fair' without further explanation. On 25 May 2018 a drill was carried out and staff response time was recorded as 10 minutes and marked as 'poor'. When we raised this with the registered manager they agreed that the times were unsatisfactory however no remedial action had been undertaken.

This was a continuing beach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at a range of records and found that appropriate steps had been taken to protect the people who used the service against risks associated with the environment.

Personal emergency evacuation plans (PEEPs) were in place for each person, detailing the support they required to leave the premises in the event of an emergency.

We saw the provider's business continuity plan which detailed what to do in the event of emergencies. This showed us that contingencies were in place to keep people safe in the event of an emergency.

We looked at the staffing levels within the service. We saw that each person had a dependency analysis completed every month to identify the level of support they required. We asked how this was then used to calculate staffing levels and were told the provider's policy was to allocate the maximum number of hours to every person regardless of their dependency score. We saw from staff rotas that the service was regularly staffed to the levels identified by the dependency tool; however, feedback we received indicated there were times when people had to wait for assistance. One staff member told us, "It can be difficult if you are working on Laurel and there are only two people on. A lot of people need two staff to support them and if

the senior is busy with meds or something you have to wait for help from another unit. People are sometimes kept waiting and I don't like that." A member of staff from the first floor told us, "It can be difficult when there are only two care staff on duty, we used to have three. A lot of people require two staff to help them mobilise, at least half of the people on this unit, so it can be difficult to manage." A relative we spoke with told us, "The only thing that concerns me is sometimes [family member] has to wait too long for the toilet. They need two staff to help [family member] but staff aren't always available. When I've been visiting I have pressed the buzzer to get help and they do come quickly but there is often only one of them and then we can be left waiting for a quite a while until they come back with another carer." A visiting health professional told us it could be difficult to locate staff at times and that staff did not always have time to accompany them to see a person.

We recommend the provider looks at the way dependency levels are calculated or how staff are deployed around the service to ensure people are not kept waiting for assistance.

Policies and procedures were in place to safeguard people from abuse. Staff had access to the provider's safeguarding policy, which detailed the types of abuse that can occur in care settings and steps staff should take to report it. Staff were also aware of the provider's whistleblowing policy. Whistleblowing is when a person tells someone they have concerns about the service they work for. Where safeguarding issues had been raised, records showed they had been dealt with in line with the provider's policy and appropriately reported to CQC and the Local Authority. One member of staff told us, "I have learned about safeguarding and I know to go to the manager with anything I am concerned about."

People told us they felt safe living at Wellburn House. One person said, "Yes they keep me safe, I'm not worried about that." Relatives we spoke with had no concerns about their family member's safety. One relative told us, "I have no concerns about [family member's] safety. I used to worry about them much more when they were at home."

The provider's recruitment procedures minimised the risk of unsuitable staff being employed. Applicants were required to complete an application form setting out their employment history, and records of job interviews showed that any gaps were explored. Proof of identify and written references were sought, and a Disclosure and Barring Service (DBS) check carried out before staff were employed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and minimises the risk of unsuitable people from working with children and adults.

Accidents and incidents were recorded accurately and analysed monthly in relation to person involved, date, time and location to look for trends. Where patterns were identified action was taken such as referral to the falls team.

We looked at the infection control procedures in place. We observed staff wearing aprons whilst giving people personal care and during meal times to minimise the risk of cross-infection. There were gloves and aprons available in many areas around the service. People's bedrooms were clean and tidy and there were no unpleasant odours in bedrooms or communal areas. We observed cleaners working throughout the day. The kitchen and laundry were clean, tidy and well organised. One person told us, "They keep my room nice and clean, I'm happy about that."

Requires Improvement

Is the service effective?

Our findings

At our last inspection in October 2017 we saw that not all staff training was up to date and made a recommendation that the provider ensured all staff had up to date relevant training in place.

At this inspection we found that none of the 61 staff employed in the service and included on the training matrix were up to date with all of the provider's mandatory training. The registered manager told us the training matrix we were originally provided was not up to date and we asked for the most up to date information to be sent to us after the inspection. When we received this information it was clear that there were still a number of gaps and out of date refresher training. Mandatory training courses are those identified by the provider as essential. Only 41% of staff had up to date fire safety training. The poor staff performance highlighted in recent fire drills was further evidence that more knowledge was needed in this area. Seventeen of the 45 people using the service at the time of our inspection required two to one support from staff for transfers and hoists and stand aids were regularly in use, however, only 46% of staff had up to date moving and handling training. Some staff had been trained in mental capacity although the training matrix highlighted that 41% of staff had not completed this course or were overdue refresher training. All care staff should also have undertaken DoLS training however only 28% of those staff had up to date training in this area.

The provider's medication policy and procedure stated that all staff who administer medicines should have competency assessments every six months. This is to ensure they are correctly applying their training and administering medicines safely. Of the ten staff administering medicines at the time of our inspection only six had undergone a competency assessment in the last six months. Two staff had not been assessed for over two years. This meant the service did not follow the provider's policy and staff had not been assessed as competent to administer people's medicines

This was a beach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff completed a seven day induction which covered all mandatory training. They were then given shadow shifts with a more experienced colleague until they felt confident to be included on the rota. The induction did not include completion of the Care Certificate. The Care Certificate was introduced within the care sector to ensure that workers had the opportunity to learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

We recommend the provider follows best practice in relation to staff induction and the use of industry standards.

Staff we spoke with were happy with the training they received. One member of staff told us, "I like the training better with the new company and we have a training file now so we can see when we're booked on a course."

Records showed people had their needs assessed before they moved into the service. During this assessment people's communication, cognitive ability, mobility and medical history was assessed. The registered manager also showed us the new preadmission falls questionnaire they had just introduced in order to establish the support the person needed and develop a personalised falls care plan.

People told us they were happy with the food at the service. One person said, "I can't complain about the food, we get plenty and it's generally tasty." Another person said, "The food is good, yes, it's very nice actually."

We spoke with the chef regarding the menu and how people with specific dietary requirements were catered for. We were shown a whiteboard in the kitchen where kitchen staff kept a record of people who needed food of an altered consistency such as fork mashable or pureed. It also contained information about people who required a fortified diet to ensure a higher calorie intake. We saw pureed meals were presented appropriately with each food item pureed separately.

Dietician referrals were made if staff were concerned about a person's weight, however, the information recorded on people's MUST charts was not always accurate. We saw that one person's MUST score had been incorrectly calculated and communicated to the dietician as moderate risk when in fact when calculated correctly it was high risk. This error could impact on how referrals are prioritised and delay an assessment. We pointed this out to senior staff and the registered manager who assured us this would be addressed immediately.

Drinks and snacks were offered throughout the day and there were snacks and cold drinks available in communal lounge areas so people could help themselves at any time.

We observed the mealtime experience in each of the three dining rooms and saw that the tables were appropriately set with table clothes, cutlery and condiments. There was pleasant background music playing at an appropriate volume and a calm, relaxed atmosphere in each area. Staff were attentive and we saw them supporting people with their meals in a dignified and patient way. There were no picture menus and no table menus of any description. The meal choices were written on a wall mounted blackboard but this was not dementia friendly or easy to read for people who had poor eyesight. Choices for lunch and dinner were made at breakfast time and staff used picture cards to help people make their selection. It is possible that people would not remember the choice they had made earlier in the day. They may also have changed their mind by the time mealtime came around and although we were told alternatives were available it was not clear when observing mealtime how these alternatives were offered. We discussed our findings with the registered manager and regional manager. The registered manager told us they were already planning to introduce picture menus and the regional manager told us there was to be a new approach to meal times with staff operating a 'show and tell' system. This meant that staff would plate up the meal options and show the two plates to each person, giving them opportunity to decide what they would like as they were about to eat rather than several hours before. These changes would improve mealtimes for people and we will monitor the progress made at our next inspection.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been submitted appropriately and CQC had been notified of any authorisations. The registered manager kept a record of when renewal applications were due to ensure authorisations were kept up to date and told us they had a good relationship with the local supervisory body who handled the applications.

Staff we spoke with demonstrated an understanding of the basic principles of MCA and DoLS. Care plans reflected good practice stating that people should be encouraged to make everyday decisions such as what to eat, what to wear and when to go to bed. One member of staff told us, "MCA and DoLS were covered in the initial training. We learn at the beginning DoLS are there for people's protection and you should always look for the least restrictive way to support someone." We saw that capacity assessments were not always decision specific and fed this back to the registered manager and regional manager. The regional manager told us there was going to be further training for staff around the importance of decision specific assessments.

Staff told us they felt well supported by management and we saw that supervisions sessions were taking place. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Records from these meetings showed they covered areas such as workload, attendance, future plans, training and development.

The service supported people to access external professionals to maintain and promote people's health and wellbeing. We saw records detailing input from community matrons, district nurses and GPs along with information relating to visits from opticians, dentists and chiropodists.

We saw that the first floor had been decorated in a bright and stimulating way suitable for people living with dementia. There was clear signage in this area, handrails had been painted in a contrasting colour to ensure they were clearly visible and people had photographs on their doors to help them find their rooms. Downstairs had recently been divided into two areas and one of these areas was also for people living with dementia. Despite this no similar adaptations had been undertaken. We were told that this had been a recent change and that signage had been ordered and a plan was being made for redecoration.

We recommend the provider follows national best practice guidance to support people living with dementia on the ground floor.

Requires Improvement

Is the service caring?

Our findings

We observed staff to be caring throughout the inspection and received positive feedback from people using the service and their relatives. However, we found that the provider did not create a caring culture within the service because staff were not supported to keep their skills updated with regular training. A failure to keep care records up to date and ensure they contained all relevant information meant that staff did not have access to accurate information in relation to people's care needs and risk levels.

People told us they were happy with the staff approach and the care they received. One person told us, "Well you mustn't grumble and there is really nothing to grumble about here. They take good care of you." Another person said, "They [staff] are all lovely. I'd like to be at home but they do look after me here."

Relatives also gave positive feedback. One relative told us, "My [family member] is happy here. Their health has certainly improved since they moved here. The staff do listen, if there is something I've raised then they've acted on it." Another relative told us, "I'm more than happy with the way staff care for [family member]. They have so much patience." A third relative said, "It's homely and all the girls [staff] are nice. They went to hospital with [family member] on one occasion and sat with them all night."

We observed positive relationships between people and staff. People were at ease in the company of staff and staff clearly knew the people they supported and their needs. There was a calm, relaxed atmosphere around the service. Staff spoke to people kindly and patiently and explained what they were doing before providing care. Interactions between staff and people who used the service were unhurried. People were given the time and support they needed at mealtimes without being rushed.

People were encouraged to maintain relationships with friends and family and people we spoke with told us about the friendships they had developed with people since moving to the service. We saw visitors coming and going throughout the day. Relatives told us they were always made to feel welcome when visiting their loved ones. One relative said, "I can come to visit whenever I want to. I've got to know a lot of the staff and the other people who live here."

Relatives told us they were generally happy with the communication they received from the service. One person had asked for more information about day to day activities and this was being provided. Other relatives confirmed that they were contacted if their loved ones were unwell. One relative told us, "I don't remember being invited to any reviews for [family member] but I have been to one of the meetings."

Staff told us how they protected people's privacy and dignity. One member of staff told us, "Dignity is in all the little things you do like shutting the door when delivering personal care. Make sure people are covered up. People here may have dementia but that doesn't mean that we should treat them any differently than we'd want to be treated." We observed staff providing care in a polite and courteous way. Staff knocked on people's bedroom doors and waited for permission before entering. One person told us, "They always knock on my door and they're always nice and polite." A relative told us, "The staff really do their best to preserve people's dignity. It isn't easy when people have to be moved with a hoist but they do it as discreetly as

possible."

We looked at how people's different religious and cultural needs were met. There was nobody currently using the service who had any diverse cultural needs but we were shown newly devised pre-admission assessment forms that looked specifically at areas of religious, and cultural needs. A local church group visited the service whilst we were there and we saw people singing hymns in one of the lounge areas. The registered manager told us that any specific requests connected to a particular religion or faith group would be accommodated to ensure people's needs in this area were met.

The manager told us one person was using the services of an advocate at the time of our inspection. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions. When we looked at the person's care records an advocate was mentioned in the person's end of life care plan but there was no further information relating to who this was and the registered manager was unable to provide any further information. We did not see any information on display regarding local advocacy services although the registered manager told us they did have some leaflets these could not be found. The registered manager told us they used the service of the local authority advocacy service if necessary but this information was not being made easily accessible for people.

Requires Improvement

Is the service responsive?

Our findings

Some care plans contained personalised information to help staff support people as individuals in a way that suited them best. Other care plans were more generic with evidence that information had been 'cut and pasted' from other people's records. For example, we saw a care plan with two different people's names on one document and both male and female pronoun's being used in the same document. An audit carried out on one person's care plan had identified a lack of person centred detail in some areas but this had not been addressed. Staff demonstrated a knowledge of the people they supported and they were able to describe to us how a person's care should be provided but the same level of detail was not always reflected in their care plans.

The provider employed two part-time members of staff to oversee and coordinate activities within the service. Their shifts were spread across seven days which meant there was a member of the activities team on duty every day. We saw some activity going on during our inspection. There was a game of bingo taking place in an upstairs lounge and singing in one of the lounges downstairs. We spoke with one of the activities team who showed us the records they kept of what had taken place previously, who had taken part and whether or not they had enjoyed it. They told us how they involved people in planning activities and tried to incorporate people's previous hobbies and interests such as knitting wherever possible. We saw posters about a pet therapy dog who regularly visited the service and another promoting the upcoming summer fete but there were no activities timetables on notice boards in any of the three areas of the service to make people and their relatives aware of upcoming events. One relative we spoke with had requested information about the activities their family member had been involved in so they could chat to them about things they had done. They told us, "[Family member] doesn't always remember what has happened through the day and it's nice for me to know so that I can start a conversation about it. They are going to put a file together for me." If activities were clearly promoted in communal areas all relatives and visitors would be able to converse with their loved ones in this way. We fed this back to the registered manager who told us activities boards had been created but not yet put on display.

We received mixed feedback from people and their relatives regarding activities. There were raised flower beds in the garden area and we spoke with one person who had helped to plant one of these and told us they enjoyed being outdoors. One relative told us there was often something going on but another said, "There used to be more going on and I think my [family member] and some others are just left sitting a lot of the time. They do bring animals and things in but that's not going on every day." We saw that in the Laurel lounge people were watching television with a member of staff and engaged in a conversation about the programme however in Lilac lounge the television was on but people were disinterested or sleeping and there were no staff around to interact with them.

We asked people if they knew how to complain. One person told us, "I'd tell them [staff] if I wasn't happy about something. I'm quite happy though so no need to complain." We looked at the way complaints were handled and found there had only been one complaint received since our last inspection. This was being investigated but the information had not been entered into the complaints log and no formal acknowledgement had been sent in line with the provider's policy. We discussed this with the registered

manager who confirmed this would be addressed and in the future complaints records would be stored in a more organised way. At the time of our inspection only formal complaints were logged which meant there were no records of any day to day concerns raised by people or their families.

Where people had 'do not attempt cardiopulmonary resuscitation' (DNAR) orders in place these were filed in a prominent location and kept under review. Some people had advance care plans in place. An advance care plan sets out a person's wishes, beliefs values and preferences about their future care. It provides a guide to help healthcare professionals and anyone else who might have to make decisions if a person becomes too unwell, to make decisions or to communicate them. We saw that one person had made decisions and documented these with the support of staff in an advance care plan. Although the form stated it was to be reviewed annually this had not been done since it was written in April 2016. This person also had an end of life care plan on their file and this document contained information which was contradictory to the information within the advance care plan. The end of life care plan was written in September 2017 and at this time the person no longer had capacity to be involved in the decisions. We highlighted this to the registered manager in order to ensure that the person's advance decisions were respected and they received end of life care which reflected their wishes.

Inadequate

Is the service well-led?

Our findings

The service had 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.

At our last inspection in October 2017 we found a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was due to audits not identifying the issues we had found, particularly around medicines. This was an ongoing breach as at the previous inspections in October 2016 and March 2016, we had identified similar concerns. The service has been rated requires improvement or inadequate at every inspection undertaken since July 2015 and the provider has again failed to make the necessary changes to improve this rating.

At this inspection we found there was still no effective system of audits in place. The provider had failed to implement a robust system to assess and monitor the quality of their service. Following the last inspection the provider had given assurances that standards would be improved and the regional and registered manager would review audits regularly. However there was no evidence that this was being done.

Care plans were being reviewed as part of the 'resident of the day' process but these checks, carried out by senior care staff, had not identified the issues we had found and care plans contained inaccurate or out of date information. The registered manager did not have a robust system for checking care plans and as a result errors were not being picked up or addressed. We saw one care plan had been audited by a registered manager from another of the provider's locations. The audit was not dated but the registered manager confirmed this was done two months before our inspection as this was when the manager had been supporting the service. This audit identified a number of issues and the action needed was recorded however we found most of the issues raised were still unresolved. One care plan was highlighted as needing to be rewritten immediately but this had not been done. Failure to identify and address incorrect care plans may result in people receiving inappropriate care.

Despite key findings from the last inspection detailing the shortfalls with the management of medicines we saw limited evidence of improvement. the provider had completed medication audits that had identified ongoing issues with topical preparations but no action plan was in place to set out the steps required and assign responsibility for improving standards. The audits had failed to identify the other concerns we found related to medicines practices.

A new regional manager had recently been appointed and explained they would now conduct a monthly audit of all areas of the service which would automatically generate an action plan. In addition to this there would be an annual audit conducted by the provider's Quality and Compliance team with reviews also carried out by the Quality and Compliance team every six to twelve weeks to monitor the homes development plans. We were given a copy of the first audit carried out by the regional manager and found that none of the actions recorded had a deadline for completion or a task owner.

Three of the five staff files we looked at did not contain a photograph of the staff member. A requirement set out in regulations for all staff employed to provide personal care. An audit conducted by the provider on 10 May 2018 had also identified some staff files were missing photographs and this was included on the action plan. However at our visit, over three weeks later, we found the provider had not carried out necessary steps to meet this requirement.

The fire safety record book stated it must be reviewed and signed every month by the registered manager and regional manager. This was not being done and the issues with poor staff response to fire drills had not been picked up by management. Records did not accurately reflect what the fire drills taking place entailed and it was not possible to establish when an evacuation drill had last taken place. Failure to identify and address the areas of concern in respect of fire drills may mean staff response in in the event of a fire may not be sufficient to ensure peoples safety.

Quality assurance surveys were undertaken annually. We saw the results from the last residents and staff surveys, although the most recent survey was being undertaken at the time of our inspection. We saw that the registered manager had responded to comments made on the surveys but no action plan had been drawn up. Four people who used the service had commented that they were not able to choose their own meals and drinks but this had not been investigated further. There was no evidence of how information from the survey was being used to drive improvement in the service.

The provider had failed to comply with the regulations as set out in our warning notice and the action plan they provided following the last inspection. This was the sixth consecutive inspection at which the provider was found to be in breach of regulations and not meeting minimum standards that people should expect. This was evidence of a lack of management oversight and a failure of governance systems.

These findings evidenced a continuing breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

An all staff meeting had been held in April 2018 and discussed topics such as staff sickness, training and holidays. Prior to this meeting the minutes indicated the previous meeting was held in May 2017. The registered manager told us other meetings had taken place but the minutes were not available to us at the time of our inspection. Staff we spoke with told us they had attended meetings but could not recall dates and therefore it was not possible to establish how often these took place.

A flash meeting was held at 11am every day. This was attended by the registered manager, care staff, the chef and activities co-ordinator. This was an opportunity to share information from the previous day about discuss the day ahead. If people had any appointments or a birthday this was raised along with any concerns about people's health or wellbeing.

Staff we spoke with felt supported by the registered manager. One member of staff told us, "[Registered manager] is lovely, very approachable, understanding and very supportive." Another member of staff said, "Compared to the places I've worked before the whole staff team here are really supportive. They have been really welcoming and happy to answer my questions." Another member of staff said, "The last year has been much better than the last six or seven. [Registered manager] has an open door and I feel they're really with us on this journey. I hope they stay, there have been so many changes."

The registered manager had sent a letter to people and their families introducing themselves after they came into post. However, most of the people we spoke with were not sure who the manager was. Two of the relatives we spoke with commented on the number of registered managers there had been at the service.

One relative told us, "There have been so many managers and so many changes. It feels like change for changes sake at times. The new manager hasn't introduced themselves yet. I just hope they stay."

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 People were not receiving care and treatment in a safe way. Regulation 12(1) Risk assessments relating to people's health, safety and welfare were not always present, accurate or up to date. Regulation 12(2)(a) Medicines were not managed safely. People were not receiving topical medicines as they were prescribed. Instructions for people receiving medicines 'as and when required' were missing or unclear. Regulation 12(2)(g) The provider was not ensuring emergency procedures were effective. Fire drills were conducted but no action was taken to address poor staff response. Regulation 12(2)(d)

The enforcement action we took:

Notice of proposal was served to impose conditions on the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to monitor and improve the quality of the service. Audits were not picking up on issues found during the inspection. Regulation 17(2)(a) Records were not complete, accurate or up to date. Regulation 17(2)(c) Action plans were not responded to within given timescales. Regulation 17(2)(e)

The enforcement action we took:

Notice of proposal was served to impose conditions on the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving regular mandatory training to ensure their skills and knowledge were kept up to date. Regulation 18(2)(a)

The enforcement action we took:

Notice of proposal was served to impose conditions on the provider's registration for this location