Leicestershire County Care Limited

Thurn Court

Inspection report

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Tel: 01162413126

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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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 27 February 2017 and was unannounced.

Thurn Court is a care home that provides residential care without nursing for up to 38 people. At the time of our inspection there were 33 people in residence. The service is located within a residential area, which provides accommodation over two floors.

This was our first inspection of the service since they registered with us on 12 October 2015.

A registered manager was 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.

We found that people's health and safety was put risk because there were not sufficient numbers of staff available and the deployment of staff was not monitored. Improvements were also needed to ensure the staff followed the infection control procedures, maintained people's dignity and ensured the environment was safe and secure.

People's health and welfare was promoted through a range of assessments and the development of care plans which were regularly reviewed. People's care plans provided information for staff as to the support people required and promoting their independence but staff did not always adhere to the care plans and people's expressed wishes and preferences. However, in practice people did not always receive care that was personalised and centred on their needs which promoted their independence and wellbeing. People were at risk of receiving inconsistent care or not receiving the care they needed in line with their wishes, preferences and outlined in their care plans.

People told us they were provided with a choice of meals. People's nutritional needs had been assessed some people were not always supported effectively to eat and drink sufficient amounts to maintain their health.

The registered manager and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed people and where appropriate their relatives were involved in making informed decisions about all aspects of their care. People were encouraged to make decisions about their day to day lives. However, in practice staff did not always gain people's consent before supporting them, offering choice or act on decisions made.

Despite the registered manager's commitment to providing quality care, concerns were expressed that the service was not well managed and lacked leadership. Throughout our inspection visit we brought issues to the registered manager's attention for action. That showed a lack leadership, oversight and co-ordination

which resulted in delays and a reactive approach to the day to day management of the service. We found the provider's quality assurance system to monitor and assess the quality of the service was not always used effectively. Further monitoring would help assure the provider that that the improvements had been sustained. People's views and opinions of their relatives and staff were sought in a number of ways.

People's safety was promoted through the employment of staff. People told us they felt safe at the service. Staff were trained and knew what action to take if they suspected that someone was at risk of harm. People received their medicines at the right times. People with the support of staff accessed a range of health care services to meet their health needs.

Staff were trained to support people and used equipment to enable people to move around safely. Further monitoring of staff's practices would help ensure people received effective care and support that promoted their rights and independence. Staff's ongoing support was being provided through individual and group meetings.

People told us staff were kind and caring towards them. People and their relatives were confident to complain and that their concerns would be addressed.

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

Requires Improvement

The service was not always safe.

Staffing levels were not always effectively managed and the deployment of staff resulted in people's needs not always met safely. Risks were assessed and plans in place to support people. However, improvements were needed to ensure measures to manage risks and infection control procedures were followed by staff; ensure people's medicines were managed safely and safety within the home environment.

People were protected from abuse because staff were trained and systems were in place to protect people from abuse. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained and being supported in their role to provide the care and support people required. Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards but consent was not consistently gained. Care plans showed people were involved in making decisions about all aspects of their care and support. People's nutritional needs were assessed. However, delay in supporting people to eat and drink affected their appetite and health. People were supported to access healthcare as required.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us most staff were caring. People's privacy and dignity was respected and maintained by most staff. People were encouraged to make decisions about their day to day lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's assessed need and care plans were reviewed regularly

but monitoring the support provided was not always effective. People did not always receive personalised care and support in line with their consent, their care plan, wishes and preferences. Staff did not always provide an explanation and at times delays in the provision of the support affected people's health and wellbeing. Meaningful conversations and interactions would promote people's wellbeing and prevent the risk of isolation.

People maintained contact with family and friends and chose how spend their time. People knew how to complain and the complaint procedure had been followed.

Is the service well-led?

Requires Improvement

The service was not always well led.

A registered manager was in post. Most people who used the service and relatives felt the service was not well managed, lacked good leadership and was reactive. They found the registered manager was not always approachable. The provider's quality governance systems was implemented but not always effectively monitored to drive and maintain the improvements.

Thurn Court

Detailed findings

Background to this inspection

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

This inspection took place on 27 February 2017 and was unannounced. The inspection was carried out by an inspector, inspection manager and an expert by experience. The expert-by-experience we used had personal experience of caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the provider's statement of purpose. This document sets out information about the service and the support people can expect to receive. We reviewed the information we held about the service and the notifications. A notification is information about important events and the provider is required to send us this by law.

We contacted health and social care professionals and commissioners for social care responsible for the funding of some people's care that use the service. Commissioners are people who work to find appropriate care and support services for people and fund the care provided.

We used a variety of methods to inspect the service. We spoke with eight people using the service and six relatives to gain their views about the service. We used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who used the service. We spoke with the registered manager, two senior carers and three staff involved in the care provided to people and the cook, activity staff and the administrator. We also spoke with the area manager, acting on behalf of the provider and two health and social care professional visiting the service at the time of our inspection visit.

We looked at the records of four people, which included their risk assessments, care plans and medicine records. We also looked at the recruitment records for three members of staff and the training records. We looked at some policies, procedures, complaints and records that showed how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People told us that their needs were mostly met but not always in a timely manner. When we asked people whether there were enough staff to meet their needs, their responses were mixed. Comments included, "Safe, definitely the staff are all good and they look after you. Sometimes they are short staffed but they work so hard", "Staffing, not really sure sometimes when you ring the bell for staff you have to wait" and "Yes I think there are enough but no less. You don't have to wait too long when you call for staff."

A relative said, "The staff here today know my mum, but they are so busy, staff don't normally sit with residents and there is always a buzzer going off or a resident calling out for help but no one seems to answer, it could be better." Another relative said, "I'm shocked today there are more staff usually you don't see anyone."

Staff also told us there were busy times and the number of people who required two staff to assist them had increased. One member of staff told us that the number of staff involved in the delivery of care had been increased but felt they were not always able to support people promptly which meant their dignity was sometimes compromised. This supported what a relative said, "Staff are trained but they don't have time to do everything properly."

We observed staff were not always available or visible so that they could assist people in a timely manner. Care provided was focused on the tasks to be carried out rather that a proactive and meaningful approach. For example at lunch time a meal was placed in front of someone but they fell asleep whilst waiting for the staff member to help them. A number of people had to wait up to 30 minutes until staff were able to assist them after everyone else's meals were served. That meant some people had lost their appetite or ate colder meals, which could affect their health. We saw the activity staff was asked to support people to eat because there were not enough staff to support people to eat. We also saw staff member sat between two people and supported them to eat at the time same.

It was evident that management did not always monitor the effectiveness of how staff were deployed and responded to meet people's needs. For example, when the call bell rang five members of staff individually walked past the electronic unit without checking who required assistance. That showed staff were not vigilant and a lack of urgency to check on people whose health and safety could be at risk as a result of the delay.

We shared our observations regarding the impact of staffing levels, the staff skill mix and deployment of staff with the registered manager and the area manager. These examples demonstrated that people were not always supported to stay safe and their needs were not always met.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations as people's safety was not assured and their needs were not always met by the numbers of staff and their skills and effective deployment.

Staff we spoke with had been trained in the health and safety and understood their role in relation to infection control procedures. We saw staff had access to protective gloves and aprons when supporting people with their personal care needs. However, we found staff were not consistently following the infection control practices. Cleaning schedules were in place however, it was evident that these were not effective. For example, because commodes were not always cleaned thoroughly it could lead to potential spread of infection and cause an offensive odour.

When we shared our findings with the registered manager and the area manager they assured us all the commodes would be thoroughly cleaned and the key code locks to the store cupboards would be fixed. The registered manager would also carry out visual checks regularly to ensure safety within the service was maintained.

We found keys were left in the door where cleaning products were stored. Although staff had used the corridor when supporting people in their rooms but were not always aware of the environmental risks that could affect people's safety. That meant people could access cleaning products hazardous to their health especially if used by someone living with dementia. When we brought this to the attention of the registered manager they store room was locked and key was removed.

A relative said, "Staff in the whole are wonderful, but I have a real bug bear when I see residents being moved in wheelchairs with no foot plates. I feel very confident to speak out and remind staff when I see this. Staff have said that they remove them as not to hit other residents' legs or it's easier to fit the wheelchair under a table." We observed this to be the case whilst people were sat at the dining table and staff replaced the footplates before people were moved.

The provider information returned (PIR) stated that medicines were stored safely. However, we found procedures had not been following in relation to the medicines stored in the fridge. Someone's prescribed eye drops in use had not been dated when opened. This is important because these items only have a shelf life of 28 days and the staff member was unable to confirm when the 28 days had past. The senior staff took action by ordering a new prescription when it was brought to their attention.

People told us they received their medicines at the right time. A senior carer told us they were trained and their competency had been assessed to administer medicines correctly. We saw the senior carer administered medicines safely and signed the records to confirm medicines were taken. They followed the correct procedure for administering medicine 'as required' such as pain relief by asking the person if they experienced any pain and recorded the amount administered. This showed that people received these medicines in a safe way and their health was monitored.

The registered manager told us that the service was in the process of moving to a new electronic medicine administration system. Staff with this responsibility were being trained. We will check this when we next inspect the service.

The PIR stated that routine fire checks were carried out and equipment used in the delivery were serviced. Records we viewed confirmed this which showed system were people lived in a safe environment.

Risks to people's physical health and safety had been assessed and identified the number of staff required to support them. These included risks of falling, being unable to walk independently and to meet people's specific healthcare needs. Care plans were developed using this information, which described the role of staff in supporting people to meet people's needs whilst promoting their safety and independence. One person's care plan documented the level of support they required and the equipment to be used to move

them safely. Staff we spoke with knew about people's individual risks. We saw staff provided one person with a soft diet due to the risk of choking, which was consistent with the information documented in their care plan.

When we asked one person if they felt safe moving around they said, "It's not such a large place and I can get around with my frame." A relative told us that when their family member moved to the service their needs had been assessed and how risks of them falling would be managed had been explained. We observed staff supporting people to move safely, they provided clear guidance and assurance to the person whilst using the equipment. Staff understood their responsibility to report incidents and accidents. Records showed that action had been taken to support the individual and to reduce further risks.

People's safety was supported by the provider's recruitment practices. Staff recruitment records showed that the relevant background checks as to their suitability had been completed before staff commenced work at the service.

People told us they felt safe at the service and with the staff that supported them. One person said, "The staff are alright they don't swear at you." A relative said, "Without a doubt I know [person's name] is safe, she would tell me and I'd go straight to the manager."

Staff were trained in safeguarding procedures as part of their induction. They understood their responsibilities to keep people safe and were confident to raise concerns with the management team and the role of external agencies. A staff member said, "I know what abuse is, it could be financial or verbal. If I saw any bruises on them or thought they weren't their usual self I'd tell the manager."

People's care records showed that when a safeguarding incident had occurred, staff documented and reported the concern to the person in charge. The registered manager had sought advice and made referrals to the local safeguarding authority, the CQC and other relevant agencies such as the Police, which they are required to do. That meant people could be assured they were protected from potential risk of harm to keep them safe as possible.

Requires Improvement

Is the service effective?

Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found conditions on the DoLS authorisation to deprive a person of their liberty were being met. A health decision-specific capacity assessment had been completed and referrals to health and social care professionals in the person's best interest had been made. Records showed people and where appropriate their representative had been involved in decisions made about all aspects of their care and treatment. That showed the principles of the MCA were followed.

The registered manager and staff were trained in MCA and DoLS. Staff we spoke with understood the importance of people consenting to their care however this was not always followed in practice. We observed a number of instances whereby staff did not gain consent before assisting people. For example, when a member of staff approached someone without warning, an explanation as to what they were about to do or consent it resulted in the person reacting physically by pushing the staff member away and verbally. We shared our observations with the registered manager and they assured us they would monitor and address staff's practices.

The menu choices were displayed close to the dining room. Kitchen staff were provided with information about people's dietary needs to ensure meals prepared were suitable for people and met health conditions such as diabetes and soft diets for people who have difficulty swallowing food.

One person told us that were involved in the menu planning and asked for comments about the meals. Other comments included, "I mostly sleep all day, and then go for dinner. Don't know what is for dinner but once you have been here a while they know what you like and don't like" and "The cook is terrible, some of the food isn't cooked properly especially the apple pie." When we asked one person if they had enjoyed their meal they said, "No it was awful I couldn't eat it."

We saw people were offered drinks and biscuits mid-morning and afternoon. Prepare drink jugs and glasses were in all the lounges. However, we did not see people help themselves to drinks independently or supported by staff. One person told us they felt unable to pour a drink because the jug may be too heavy for them to hold.

People's care records showed their dietary needs, preferences and the support they needed to eat and drink

were documented. Where people with specific health risks such as poor appetite or weight loss care plans were in place. However, we saw staff did not always follow people's care plans and provide the support people needed to eat. We observed the meals being served at lunch time in the dining room. Vegetable dishes and gravy boats were placed on tables where people did not require assistance but there were no condiments. We saw the kitchen staff showed some people two different plated meals so that they could choose what they wanted to eat. However, care staff did not always show people the choices and did not always act on people's requests. For instance, when someone asked a staff member for a banana instead of a desert they were given a bowl of fruit crumble and custard. One person was taken to the dining room but did not want to eat so they sat watching others eat.

We shared our observations of the lunchtime meal experiences with the registered manager and the area manager who assured us action would be taken. The registered manager told us that 'flash' meeting' would be used to address any concerns were identified with regards to staff's practices.

Staff told us that the training had helped them in providing care to meet people's needs. Records showed staff had received training in a range of topics to support the health, safety and well-being of people and nurses' competency to meet healthcare needs had been assessed. However, we saw a number of instances whereby the support provided was focused on the tasks and not centred on people and how they wished to be supported. For example, a staff member attempted to place the sling behind someone to move them, without any communication and startled them. Another staff member then explained what they were about to do and gave the person time to respond and was moved safely.

Most staff felt supported by the registered manager. Staff told us that the meetings were used to reflect on their work and identify training needs. Records showed that staff were supervised on a regular basis and had an annual appraisal.

People had access to a range of health care services to meet their ongoing healthcare support and records viewed confirmed this. A relative said, "If she [family member using the service] needs to see a doctor they've always called for a home visit and will let me know so I can be here at that time." Staff member told us if they had any concerns about people's health they would be shared with the relevant health care professional to ensure the care provided remained effective. The visiting health care professional we spoke with confirmed this to be the case. They had provided staff with training to help prevent the risk of people development skin conditions which meant staff had sought advice if they had concerns about people's health in a timely manner.

Requires Improvement

Is the service caring?

Our findings

Staff told us they had received training in topics that were related to the promotion of people's privacy and dignity. However, we saw instances where people's dignity was not always maintained by staff. Some people used an apron to protect their clothing when they ate. However, staff did not always offer to support people to change their clothing if they had spilt food on their clothing. We saw staff member retrieved a biscuit from a pile of magazines and assisted someone living with dementia to eat it. We saw another person's dignity was not maintained in relation to managing their specific health needs. We shared our observations with the registered manager who told us that blankets were available for use and assured staff would be reminded of the importance to maintain people's dignity.

We asked people whether staff respected their privacy. One person said, "I'm not embarrassed when staff help me with my personal care, they are very good, and they put you at ease, no problem. They are all wonderful I can't fault them." A relative said, "I have definitely seen privacy and dignity carried out when mum has received personal care."

A staff member told us that people's bedrooms were respected as their own space and they would knock before entering people's room. We also saw staff offered to assist people with personal care before they went to the dining room for lunch. That meant people's experiences of how staff promoted and respected their privacy and dignity was varied and not always consistent.

People we spoke with said that staff treated them with care most of the time. All the relatives we spoke with stated that staff were kind to their family members. A relative said, "They [staff] understands she gets confused and can be difficult but they always treat her well." Another relative said "The staff on the whole are absolutely superb, always make you welcome, inviting you to eat a meal with mum if you want to."

People's decisions made were documented about how they wished to be supported. People told us that most staff respected their wishes. Care plans had clear information about people's health, and the care and support they needed.

Some staff we spoke with were aware of people's preferences and we saw them supporting people in line with how they wished to be cared for. A staff member described people's individual needs, routines and the support people required. Another said, "We get updates on people at the handover meetings. If you're not sure then just ask the senior or read the OCR book [daily care record]."

Staff understood and respected people's confidentiality. People's confidential information such as care records were kept secure within the office and doors were closed when staff discussed people's care needs. That meant people could be assured their confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

People told us that they had made a decision to live at Thurn Court. A relative told us that that they were involved in the assessment and care planning process to ensure their family member's needs were identified and care plans were in place to meet those. Another relative said, "I was involved in mums care plan but it was a while ago, can't remember any review."

Records showed people's needs were assessed, monitored and reviewed and their care plans were amended when their needs had changed. There was clear information for staff to follow to support someone who could become or agitated. However, we observed instances whereby people were not cared for in line with the wishes as detailed in their care plan. For example, someone's care plan stated they preferred to sit on their own and managed to eat using a spoon. However, at lunchtime this was not the case as they were sat in the dining room and struggled to eat using a fork. That meant the person's independence with eating was not promoted and their decision not respected.

We found people did not always receive personalised care that was responsive to their needs. Staff supported people with little or no engagement, did not always explain what they were about to do, gave people time to respond or consent. We saw people were distressed and anxious when staff used a hoist to move people. The discomfort could have been avoided if the member of staff had explained what were about to do and offered the person reassurance at every stage of the process. These observations were shared with registered manager.

Lunchtime meal experience was chaotic and noisy. A number of people waited up to 30 minutes before their meal to be served. One person became upset when their meal eventually arrived and only ate a small amount. Some people had to be assisted by staff to eat. The delay for some people resulted in them falling asleep or lost appetite. Staff were not vigilant or responsive when someone was visibly concerned that the person sat next to them had not eaten and fallen asleep. We intervened and informed the staff member who woke the person up and reminded them to eat. The staff member spent no time to support the person who was living with dementia, provided an explanation or described the food on their plate or assist them to eat.

We saw staff provided support that was focused on task, lacked sensitivity and encouragement to help promote people's health and wellbeing. For example, a staff member assisted one person to eat but did not speak with them. Instead they spoke to another member of staff who was assisting someone else on another dining table. Another member of staff was sat assisting two people to eat at the same table without any conversation or encouragement. The staff member missed the opportunity to respond to someone's facial expressions used to communicate as their speech was limited. A third staff member took the plated meal away and showed no concern as to why the meal had not been eaten. These were examples of the lack of personalised care which potentially puts people's health and wellbeing at risk.

The service had links with the local schools. There were photographs of the seasonal events such as Christmas carol singing and the planned activities displayed. We saw the armchair exercise was advertised for the day but stated 'November 2017'. This was amended when we informed the registered manager.

The service employed a dedicated activity staff who had responsibility consult and organise activities that were of interest to people. They gave examples of events and activities that they had organised which people had engaged in. On the day one of the activity organised was armchair exercise. We saw most people in the lounge took part and were enjoying themselves. This activity was interrupted by the staff member who brought in the tea trolley and insisted that drinks had to be served then. This was an example of staff being focused on tasks and regimes and did not recognise the importance of promoting people's wellbeing and people's care and support being flexible.

We received mixed feedback about the opportunities people had to take part in activities. One person said, "Oh it's very boring here, I just sit here all day sometimes fall asleep. I don't go into the lounges as there's always programmes on the TV about building and selling houses, I don't know what to do with myself." Another person said, "I like living here people are nice, I watch TV and read. I'm happy enough."

This was a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people did not receive personalised care and support to promote their independence and wellbeing. That meant they were at risk of receiving inconsistent care or not receiving the care they needed in line with their wishes, preferences and outlined in their care plans.

People and relatives told us they knew how to complain. People found the complaint procedure easy to follow. One person said, "If I needed to complain I would go to the office or talk to my daughters." A relative said, "We've got no concerns. If we had any complaints, first I'd talk to the manager. If needs be I will go to the authorities [external agencies] but never had to."

The complaint procedure was displayed in the foyer of the service. The contact details for the local authority and advocacy service were included should someone need support to make a complaint.
Records showed four complaints were received and the complaint procedure had been followed.

The service had received a number of positive testimonials about the service, the staff and the care provided to people. The registered manager looked at all the compliments and used the feedback to help monitor the quality of service.

Requires Improvement

Is the service well-led?

Our findings

This was our first inspection of the service since they registered with us on 12 October 2015. A registered manager was 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.

The registered manager was aware of the CQC's approach and gave examples to support the five key questions we ask about services, in that is the service safe, effective, caring, responsive and well-led. They had clear visions and values about the quality of service people should expect to receive. However, it was evident from our observations that they lacked any oversight and awareness of people's experiences which meant those were values were not put into practice.

We asked people who used the service and relatives for their views about how well the service was managed. Their responses were mixed and included, "No I don't think the home is well run, the manager always seem too busy to spend time with you" "On the whole mum is happy and staff are good as gold but it's a lack of communication and staff. Mum can be in the dining room at 12 noon and still there at 2pm" and "Well run, no, lack of management, trying to do too much with little staff." A relative said "Well run yes but the laundry is a nightmare" as they showed us grey shades of clothing that use to be white.

The feedback we received supported our own observations about the lack of effective monitoring on a daily basis to ensure the service ran smoothly. For example, staff missed opportunities to have meaningful conversations and engagement with people whilst being supported and in passing. The lunchtime service was chaotic, as there was lack of co-ordination amongst the staff team and leadership. Throughout our inspection visit we brought issues to the registered manager's attention for action. On one occasion we alerted the registered manager who was in their office was adjacent to the dining room that there were no staff in the dining room to assist. Similar incidents could be avoided with effective monitoring, observations and leadership.

Staff meetings were used to discuss the quality of the service and areas for development. The meeting minutes showed that staff had raised issues about the cleanliness of the commodes which had resulted in a cleaning schedule being introduced. However, based on what we found further action was required to monitor the effectiveness of the cleaning schedules.

Staff's ongoing training and support was planned which helped to assure people that they were supported by staff whose knowledge was kept up to date. Despite the support and training it was evident from our observations, feedback from people who used the service and relatives that management and staff's values, attitudes and behaviour were not consistently focused providing quality care.

Although staff felt involved in the running of the service, some concerns were expressed that they were not always able to speak to the registered manager in private. This was raised with the registered manager and

they assured us that when required they had moved to a private room or asked other staff to leave the office.

We spoke with the area manager to find out how they assured themselves of the quality of the service they provided. They had carried out quality monitoring visit in January 2017. The report detailed the areas checked such as premises, care records and feedback for people who used the service. The action plan detailed the areas to be improved and staff member with the delegated responsibility, for instance to update the care plan guidance for staff to follow. The area manager had rated the service as 'good' but had no supporting guidance to support the judgement. This could lead to inconsistency in judgements made about the quality of service provided. We found the care plans had been updated but the quality of care provided by staff was not always consistent or well managed.

The provider had a quality assurance system which identified the frequency of audits carried out and action plan to address shortfalls identified. Various monthly audits had been completed such as audits on people's care plans, medicines management, the infection control and the premises and daily checks on the management of medicines. However, these did not always effectively drive improvements. For example, staff had not questioned why the prescribed eye drops in use was not dated when opened. The January 2017 medicine audits showed a number of missing signatures continued to be identified. These were similar issues had been identified from the contracted dispensing pharmacy audit in September 2016.

We found people's care plans detailed the support required to meet their needs and were reviewed regularly; we found day to day monitoring was not always effective. For example, it was identified people's intake of food and drinks should be monitored. Staff documented what the person ate and drank but no one had assessed whether that was sufficient or sought advice to ensure the person's nutritional needs were being met. Furthermore, audits carried out on people's care records did not always result in changes made to care plans and the support provided by staff. As a result people's needs were not always being met, timely, safely and in line with the person's wishes.

The provider information return (PIR) was comprehensively completed. However, in practice the quality of the care and support provided and the management of the service was not reflective of what we found. The provider had procedures, documentation and systems in place but those were not effectively monitored.

This was a breach Regulation 17(2) (a) (b) (e) under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 because the governance system was ineffective and quality of service people received was not well managed.

The provider had a system to support the registered manager to analyse information such as accidents, incidents, complaints to establish any trends or pattern. Records showed people's care needs and risks had been re-assessed and if required were referred to health care professionals for advice and support.

The registered manager told us that they encouraged people to express their views about the service and influence how it was run. People could use the comment cards to provide feedback. Residents' meetings were held regularly but were not always well attended for instance only two people attended the meeting in January 2017. Minutes showed that alternative times had been considered and that people's views had been sought about the home's décor.

When we asked a relative if they were asked for their views, they said, "Quality questionnaire yes but can't remember when. Although I have made comments regarding wheelchair footplates they don't seem too acted upon." We observed that staff often pushed the footplates to the side whilst people were sat at the dining table and put in place before people were moved. The registered manager told us the satisfaction

surveys had been completed and the resulted were being analysed. They told us that the results would be shared with people at the next residents' meeting and the areas that they had identified that required improvements.

Prior to our inspection visit we contacted the local authority commissioners responsible for the care of people who used the service. They told us that at the last contract monitoring visit in September 2016 some issues had been identified in relation to people's safety and dignity and the management of medicines. The registered manager shared with us the actions taken including the supporting evidence that was sent to the local authority to demonstrate practice.

We received positive comments about the registered manager from health and social care professionals we spoke with. They found the registered manager to be approachable and focused on meeting people's care needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care and support that promoted their independence and wellbeing. People were at risk of receiving inconsistent care or not receiving the care they needed in line with their wishes, preferences and outlined in their care plans. This was a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not well managed and lacked leadership. The systems to monitor the quality of service were not used effectively and as a result put the health, wellbeing and safety of people who used the service at risk. 17 (1) (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People's safety was not assured and their needs were not always met by the numbers of staff and their skills and effective deployment. Regulation 18 (1).