Norens Limited

Homecrest Care Centre

Inspection report

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Date of inspection visit:
05 February 2019
06 February 2019

Date of publication:
15 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 5 and 6 February 2019. The inspection was unannounced.

Homecrest Care Centre 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. The home offers accommodation for people who require support with their personal care. There are 29 single bedrooms with a passenger lift enabling access to bedrooms on the upper floors. Four of these bedrooms are reserved for people who require emergency admission to the home or respite care.

On the day of our visit, 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. At the time of this inspection, the registered manager was absent from work and had been for some time. An interim manager was in post to manage the service in their absence. The interim manager commenced in post in September 2018.

At our last inspection in July 2018 we identified breaches of Regulations 9, 12, 13, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to person centred care, the management of risk, the safeguarding of vulnerable adults and the governance arrangements in place at the home. After the July 2018 inspection, the home was placed in special measures. CQC served a notice to add a condition to the registration of the service with CQC. This condition meant that the home had to seek permission from CQC if they wanted to admit any new person to the home

At this inspection, we checked to see if the provider had acted on the concerns we had identified. At this inspection the standards of care at the home had improved significantly but the provider still had some improvements to make to achieve full compliance with the health and social care regulations. This was because there were continued breaches of regulations 12 and 17 identified again. At the last inspection, the service was rated overall inadequate. At this inspection as a result of the improvements made, the service has been rated 'requires improvement'.

We found that the majority of people's needs and risks in the delivery of care were assessed and had suitable management plans in place for staff to follow. Further action was required with regards to the support of one person's health condition and two other people's mobility needs. A recent trip out organised for two people who lived at the home had also not been properly risk assessed or managed. These issues meant that the provider had not sufficiently responded to the concerns we identified at the last inspection with regards to risk management.

At the last inspection the management of medication required improvement. At this inspection, the

management of medicines had declined further. This placed people's health and well-being at risk. We found that medicines were not properly accounted for. This meant it was difficult to tell what medicines had been received into the home and whether they had been administered correctly. We spoke with the interim manager about this. They agreed that urgent action needed to be taken to ensure medication management was safe. After the inspection, we referred our medication concerns to the local authority for investigation.

The system in place to identify and respond to potential incidents of abuse had improved to protect people from risk but notifications of potential abuse to CQC had not always been made.

The provider had still not ensured that the home's electrical installation was certified as safe to use. We drew this to the provider's attention again and it was subsequently organised. It should not have taken inspectors however to have to point this out again to the provider before action was taken.

The communal lounge, dining room and some people's bedrooms had been redecorated. New flooring, armchairs and other furnishings had been purchased which made these areas bright and fresh looking. The home was cleaner and no longer smelt. A new boiler had been purchased to ensure there was sufficient hot water in the home and a sluice room for the washing and disinfecting of people's personal items was in the process of being installed.

We saw that people got enough to eat and drink and at this inspection people's opinions on the food provided was positive. At lunchtime we saw that some improvements to the way people's meals were served had been made. For example, there were tablecloths and napkins on the table, people were given a choice of two meal time options and there was appropriate cutlery for people to use to maintain their independence. People who needed help to eat and drink received support to do so. Further improvements were required to ensure that people were not waiting a long time to be served their first course once they had sat down at the table for their meal.

During our visit we noted that people were smartly dressed and looked well cared for. Records showed that they had received regular access to a bath or shower, oral hygiene and other personal hygiene support. People's care had improved to meet their individual needs. People also had access to a range of in-house activities to occupy and interest them in support of their emotional and social well-being. Activities or trips outside of the home were still not routinely organised despite people's expressing a preference for this at the last inspection.

At this inspection, staffing levels had not changed from the previous inspection but there were fewer people living in the home. At the last inspection the service was chaotic and disorganised. At this inspection, staff had the time to support people in a person centred way. The atmosphere was much calmer and relaxed. This was a significant improvement.

Staff recruitment was safe and the interim manager had ensured all appropriate pre-employment checks had been undertaken prior to new staff commencing work at the home. Staff had received training and support to do their job. People we spoke with and their relative were all positive about the support provided. No-one we spoke with at the time of the inspection had any complaints.

The provider's governance arrangements for the monitoring and management of the service had improved but were still not sufficiently effective in identifying quality and safety concerns.

The overall rating for this provider is 'Requires Improvement'. However the safe domain's rating has not

changed and due to the concerns identified remains rated as inadequate. This means that the service will remain in 'Special measures'. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some people's risks were fully assessed and acted upon. Others were not.

The management of medication was unsafe and it was difficult to tell if medicines had been administered correctly.

The provider had not ensured the home's electrical installation was certified as safe for use.

Safeguarding incidents were appropriately identified and investigated to protect people from potential harm.

New staff members were recruited safely. There were enough staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The majority of people whose care files we looked at had their capacity assessed in accordance with the Mental Capacity Act 2005. One person did not.

People got enough to eat and drink. People's meal time experience had improved but some people's meals were not served in a timely manner.

Staff had completed suitable training. The interim manager had commenced a programme of supervision meetings with the staff team.

People had access to a range of health and social care professionals with regards to their well-being.

Is the service caring?

Good

The service was caring.

At this inspection, staff had more time to support people. Staff

were polite, kind and patient in all of their interactions.

People's friends and relatives were able to visit without restriction and we saw that the staff team supported people to maintain these relationships.

People told us staff knew them well and were happy with their support.

People had access to advocacy services to help them understand their care and the choices available to them. This was good practice.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had access to a range of in-house activities. Access to trips or activities outside of the home had not been organised in response to people's feedback at the last inspection.

People's end of life wishes had not always been discussed or documented to ensure that in the event of ill-health these wishes were respected.

Staff provided people with personalised support in response to their needs.

The people we spoke with had no complaints. Everyone was happy with the support provided. This was an improvement from our last inspection when people's views were mixed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Significant improvements to the service had been made since the last inspection but progress was ongoing at the time of this inspection.

Some of the governance arrangements in place were not robust as they failed to identify and respond to some of the concerns identified at this inspection.

Statutory notifications had not always been submitted to CQC in accordance with the provider's registration requirements.

The interim manager had made a positive start to improving the home in conjunction with the provider.

Homecrest Care Centre

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 5 and 6 February 2019. The inspection was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service. Prior to our visit we looked at any information we had received about the service and used this to plan our inspection.

During the inspection we spoke with six people who lived at the home, a relative, a care assistant, the interim manager, the assistant manager, the maintenance officer and the activities co-ordinator We also requested feedback on the delivery of the service from the local authority.

We looked at the communal areas that people shared in the home and some of their bedrooms. We reviewed a range of documentation including six care records, medication records, two staff files, policies and procedures, health and safety audits and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection of the service in July 2019, the provider was found to be in continued breach of regulation 12 (safe care and treatment) and regulation 13 (safeguarding people from the risk of abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the care people received was not always safe as it failed to mitigate risk to their health, safety and welfare. Concerns were identified with regards to the environment in which people lived and how people's medicines were managed. Incidents of a safeguarding nature were also not properly recorded, investigated or reported to appropriate bodies.

At this inspection, although the provider had made some positive improvements we found that they remained in breach of regulation 12. This was because some people's risks had not been properly assessed or responded to and the management of people's medications remained unsafe. We found that the concerns we had identified with regards to regulation 13 had been addressed as safeguarding incidents were now properly identified and investigated to protect people from harm.

During our visit, we looked at the care plans belonging to six people who lived at the home. We saw that people's risks in relation to skin integrity, malnutrition, moving and handling and personal care were all assessed. There were risk management plans in place for staff to follow to reduce any potential risks and people's daily care records showed that these had been followed to protect them from harm. One person however had a specific health condition. Documentation in the person's care file showed that the provider had been asked to seek out special equipment to support this person's well-being. At the time of our visit, this advice had not been acted on. One person's mobility needs required further assessment to ensure that the support provided was safe and appropriate. We spoke with the interim manager about these issues. They told us they would act on them without delay.

At our last inspection, the management of medicines was not safe. At this inspection we found that the management of medications had declined further. We checked a sample of people's medications. We found that the system in place to account for people's medicines was inadequate. For example, some people medicines had not been booked into the home appropriately. This meant there was no record of these medicines being received into the home from the pharmacy. It also meant that it was difficult to check that the amount of medication in the home was correct. We looked at people's medication records and found that these records did not detail the amount of medication carried forward from one medication cycle to the next. This meant it was impossible to tell if the correct amount of medication had been administered. One person's medication did not have a medication records in place to record its administration yet six tablets had been administered. Some people had medication in stock at the home that had not been administered to them for some time. Despite this, the home had continued to order this medication. This resulted in a surplus stock of medication that had not been returned to the pharmacy in accordance with best practice.

These examples of people's care demonstrate a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people's medications were stored securely and at safe temperatures to ensure the quality of their medications were maintained.

At our last inspection, the home's electrical installation certificate was not available. This meant there was no evidence that the home's electrical installation was safe. At this inspection, there was still no safety certificate in place. We raised this again with the interim manager. On day two of inspection, the interim manager told us that they had contacted the provider and arranged for an electrical safety check to take place the following week. It should not have taken inspectors to point this out again to the provider before any action was taken.

Weekly health and safety checks were completed by the maintenance officer. Checks on the home's gas installation, fire arrangements, emergency lighting and legionella checks were all regularly undertaken.

Since our last inspection, the environment in which people lived had significantly improved. At our last inspection, parts of the home were unclean and smelt unbearable. At this inspection, the home's communal areas and some of the bedrooms had been redecorated. These areas were now bright and fresh looking and the home no longer smelt offensively. New flooring had been installed in communal areas and the provider had purchased a new boiler which meant that people had access to hot water at all times. A sluice room for the washing and disinfection of people's personal items was also in the process of being installed.

We looked at three staff files and saw that staff members were recruited safely. Pre-employment checks were completed to ensure the staff member was suitable to work with vulnerable adults. For example, previous employer references were sought, a criminal conviction check undertaken and the staff member's personal identify was checked before they were permitted to work in the home.

At our last inspection, we advised the provider that staffing levels at the home required review. People had mixed opinions on whether there were enough staff on duty to meet their needs. Staff were very busy with the practical aspects of people's care and had little time to provide reassurance to people who had become upset or who needed reassurance. At this inspection we found that the number of staff on duty was sufficient to meet people's needs and the people we spoke with confirmed this. The number of staff on duty had not changed since our last inspection but there were less people living in the home. People's comments included "I find it's okay. [Staff] are always available if you need them. Touch wood, I've always been able to get someone", "I think [there are enough staff], yes. Not very long [to wait for support]", "Oh yes [enough staff]; I don't have any worries about that. They have lots of things to do and "You don't have to wait too long [for staff support].

At this inspection, safeguarding records showed that any incidences of potential abuse were logged, recorded and investigated by the provider or the local authority. We found however that they had not always been reported appropriately to CQC. We discussed this with the interim manager who told us this would be improved upon immediately.

At our last inspection some people did not feel safe living at the home. At this inspection, this had changed and everyone we spoke with felt safe. People's comments included "Yes [I feel safe] and I've always found staff very nice. The way they speak to you is very nice"; "Oh yes [I feel safe] and "It's [The home] very safe; no concerns".

Accident and incident records showed that appropriate action was taken when an accident and incident occurred in order to minimise the risk of the accident and incident occurring again in the future.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, the people had mixed views about the support they received. Some thought the support was good, others did not. At this inspection, everyone we spoke with thought the support was good and that staff had the skills and experience to meet their needs.

At our last inspection, although there was a handwritten menu displayed on a blackboard with two mealtime choices, people were not asked what they wanted to eat and were given a meal based on what the staff member though the person liked and disliked. This was not good practice. At this inspection we heard staff asking people what meal they would prefer out of the two options available. We also saw that if the person did not like what was on offer they were provided with an alternative meal of their choosing. This was an improvement since our last inspection.

The environment plays an important role in how much a person enjoys their meal. It can affect how much the person eats. A relaxed, social atmosphere at mealtimes can have a positive impact on a person's health and well-being. At our last inspection we found that people's mealtime experience was disorganised. The tables in the dining room were not set before people sat down to eat and some people were still being assisted into the dining room by staff at the same time as others were eating their meal. At this inspection improvements had been made.

The dining room tables were set before lunch with pleasant tablecloths and napkins. People were assisted into the dining area and we saw that staff had the time to ensure everyone was sat down before people's meals were served. People who needed assistance to eat where provided with this support in a calm and sensitive manner. We found however that the time taken to serve people their meals was slow. Some people sat for over twenty minutes before their meals were served. This was because one of the lunch time options (omelette) had to be cooked from scratch at the time of ordering. This resulted in a queue of people waiting for their meals.

At the last inspection people opinions about the food and drink on offer was mixed. Some people stated that the quality of the food provided had declined. At this inspection, everyone we spoke with was positive about the food and drinks they were provided with. People's comments included "The staff know what kind of food I like. The meals are always nice. [Name of assistant manager] tells us what's available and asks us what we'd like. There's always plenty to eat. They come round with drinks all day long", "[The food] is lovely; absolutely beautiful" and "It's very good; there's always plenty".

We saw that kitchen staff had up to date information on people's special dietary requirements. People who needed extra nutrients had their meals fortified and some had additional dietary supplements to help them maintain a stable weight.

We saw that people received sufficient amounts to eat and drink. One of the people whose care file we looked at was in receipt of support from the community dietician. At this inspection we could see that the person's weight had stabilised and that they had been discharged from dietetic services. This was a good

outcome for the person and showed that staff at the home had followed professional dietary advice to ensure the person gained and maintained a healthy weight. Records showed referrals to other community based healthcare services were also made as and when required. For example, specialist medical teams, dentists, district nurses, psychiatry, audiology, opticians and podiatry.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We found that where there were concerns over a person's capacity to consent to a specific decision, the majority of people had their capacity to consent assessed before a decision was made. There was only one person out of the six care files looked at where a capacity assessment had not been undertaken when it should have been. This person had a deprivation of liberty safeguard in place with no evidence that this safeguard was needed to keep the person safe. We spoke with the interim manager about this. They told us they would investigate the circumstances in which this person's DoLS was put into place.

We looked at staff training information and saw that staff members had received sufficient training to do their job role. Training was provided in a number of health and social care topics such as safeguarding, food safety, infection control, moving and handling, dementia awareness, nutrition and hydration and dignity. Since our last inspection, the assistant manager had also attended training in diabetes and had become the lead for diabetes within the home.

The interim manager had a supervision and appraisal schedule in place which showed when each staff member's supervision and appraisal meetings were due. The interim manager had yet to complete a supervisory and appraisal meeting for all staff members. This was because they had only been in post for four months at the time of this inspection. At our last inspection we had no concerns about the supervision and support staff received in respect of their job role.

Good

Is the service caring?

Our findings

At this inspection we found staff to be kind, caring and respectful of people's needs. People we spoke with happy with the support provided. We observed positive and friendly interactions between the people who lived at the home and staff.

People's comments about the staff team included "There's always a cheery 'good morning, did you sleep ok?'– things like that", " [Name of carer] is lovely – she's giving me a smile now, look. They're so nice, "My angel without wings [referring to a carer]; I call [another carer] Blondie. I like people who can laugh and be fun. We all get on great – we laugh and joke and get on well together" and "They are very kind indeed". A relative also told us "They [the person] are happy. They get on well with all the girls. You always get a cup of tea as well.

We saw that people were supported to see their family, friends and other visitors. There were no restrictions on when or how long family and friends could visit for. People's care plans contained information on their network of family and friends so that staff were aware of the relationships that were important to people. The interim manager told us that staff had assisted one person to move bedrooms to enable them to have more room and privacy to meet with their family.

At our last inspection we observed a rushed staff team who had little time to engage with people in any meaningful way. At this inspection, with less people living at the home, we saw that the same number of staff had more time to chat to people throughout the day.

At the last inspection we found that some people who lived at the home paced up and down or congregated in the entrance area of the home in states of agitation or distress. At this inspection, everyone who lived at the home was sat comfortably and relaxed in the lounge. The atmosphere at the home had significantly improved and we saw that this had had a positive impact on people's emotional well-being. A staff member we spoke with told us that they thought the atmosphere at the home had changed as a result of having "Less people (to support)" which meant "We can give one to one time to people more, which people like".

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over and provided appropriate aids to support them to be independent, such as plate guards and adapted drinking cups.

People's care files showed evidence that they had been involved in the planning and delivery of their own care. This was because there was a good level of person centred information in people's care plans that indicated staff had either talked to the person and/or their relatives about their wishes in relation to their care.

Records showed that people had access to advocacy services to help them make decisions about their care and treatment. Advocacy services help by representing the person's views and ensuring the person's rights

are respected during discussions about their care. This was good practice and showed that the service cared that people's wishes and best interests were promoted.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection the home was in breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some people needed support and reassurance from staff for their behavioural or emotional needs but staff were too busy with other tasks to provide it. People who lived at the home had little to occupy and interest them. For the majority of the day they sat without any meaningful interaction from staff or others. Emergency admissions to the home for people who needed accommodation and support quickly were also accepted without a proper assessment to ensure staff could meet their needs. This placed further demands on an already busy staff team. At this inspection we found that the provider had taken action to address the majority of our concerns. This meant the provider was no longer in breach of Regulation 9. Further improvements were however still required.

After the last inspection, CQC placed a restriction on the provider's admissions to the service. This meant that the provider was unable to accept any new admissions to the service without the permission of CQC, either permanent or emergency admissions until significant improvements were made. At this inspection, we saw that the restriction on admissions had had a positive impact on the service. The number of staff on duty had not changed from the last inspection but with less people to support, the staff team were unrushed. We saw that they were able to interact with people in a much more meaningful way and the atmosphere at the home was much calmer and pleasant. During our inspection we did not see any of the people who lived at the home in a state of agitation or distress and people sat in companionship in the lounge area with their peers.

We observed that the activities co-ordinator engaged with people in an appropriate way. They ensured that everyone who wanted to, was able to participate in the activities provided. On the day of our inspection, there was a pampering session in the morning and in the afternoon a session reminiscing about the 'old days' with a series of photographs. We saw that the activities co-ordinator encouraged and prompted people to join in the discussion. One person who we had not seen engaging in any conversation previously was quite engaged in this activity and was able to share a memory they had with others.

At our last inspection, people told us that the opportunity for them to enjoy trips and activities outside of the home had declined. At this inspection we saw that a couple of people who lived at the home had a one off outing with the activities co-ordinator in December. The interim manager also told us that one person regularly attended a local dementia café. We found however that group outings had still not been organised for most of the people who lived at the home. The activities co-ordinator told us they had no specific budget for activities and was spending their own money on activity materials. They said they were still having to subsidise the activities out of their own money. They said 'I've been told there's no budget. I'm paying for everything – papers, pencils, games, adult colouring books etc. Art stuff I buy myself; I've built up my resources. I haven't been told I'll get a budget".

We spoke with the interim manager about this. They told us there whilst there was no specific budget for activities, the activities co-ordinator was able to access petty cash for activities. They told us that the activities co-ordinator had not requested any of the petty cash money. They acknowledged however that

there was no set budget for how much petty cash money could be used for activities. This meant it would have been difficult for the activities co-ordinator to forward plan a programme of activities. It was clear from the conversations we had with the activities co-ordinator and the interim manager that the process of organising and requesting petty case monies for activities was not properly understood. The interim manager told us that a trip out for people was planned for in the spring. It was unclear whether this was a one off activity or whether the provider had plans to provide a regular programme of trips and outings in response to people's feedback at the last inspection.

The activities co-ordinator told us that they did ask people what activities they enjoyed but there was no documentation to evidence these discussions. A resident's meeting had not taken place since August 2018 so it was difficult to tell if people had been involved in discussing and deciding upon the activities and outings they would like to participate in. This aspect of service delivery still required further development.

At our last inspection, people were not permitted free access to the garden. At this inspection this was the same. When we checked the garden area we found it to be unkempt and parts of the paving were uneven. It would have been difficult for people to use the garden on their own. Seating in the garden area was provided but was unsuitable for people with mobility needs as the chairs were old and some had no arms to help people to move from a sitting to standing position. We spoke with the interim manager about this. They told us they had plans to renovate the garden area and put in a raised flower bed so that people could enjoy planting flowers or a herb garden. They acknowledged that the garden required attention. When we returned to the home on day two of our inspection, the interim manager told us they had contacted the provider and that they had agreed to relay the paving slabs to ensure it was safe for people to use.

From people's care plans we saw that staff had sufficient information about the person to enable staff to gain an understanding of the person they were caring for. There was information on the person's life history, family networks and likes and dislikes. The interim manager told us that a local college student was completing work experience at the home. They had a project to work on within the home that involved chatting to people on a one to one basis about their life in order to build- up more detailed life histories. They told us that this work was still in its infancy but that people seemed to enjoy the time spent with the student.

At our last inspection there was no evidence people's end of life wishes were discussed or planed for in any meaningful way. At this inspection this remained the same. End of life, advance care planning is important. It ensures that people's future health decisions and end of life preferences are known to staff and other health care professional at a time when they may be too unwell to make their own decisions, or communicate their wishes.

We saw that people's needs and care was reviewed each month. Where people's needs had changed people's reviews generally documented these changes but the person's care plan had not always been updated with this information. This meant at times people's information was confusing.

People we spoke with felt staff knew them well. People's comments included "Yes, we chat and [the staff] know a bit about me", "They know me; they ask me", "They like talking; we're friends. They know a bit [about me]" and "I don't feel lonely here. I have made friends". A relative also told us "They treat the residents as individuals, not just as a standard".

We observed that staff were responsive to people's needs. Support was provided in a patient and respectful way. People looked relaxed and comfortable with the support provided by staff.

At our last inspection, we noted that some people who lived at the home looked unkempt. The clothes of some people also smelt. When we looked at the records maintained in respect of the personal care people received, we found limited evidence that people had access to regular bath or showers. At this inspection we saw that positive improvements had been made. All of the people who lived at the home at this visit looked well after. Records showed that people were offered a bath or shower every day in support of their personal hygiene.

No formal complaints had been received by the manager in respect of the service since our last inspection in January 2018. People and the relative we spoke with told us they had no complaints or concerns about the care they received. One person told us "There's nothing that makes me unhappy. My room is only small but I do like it". Another person said "I've always liked it [at the home]". We also saw that since the last inspection, the service had received a number of compliments about the support provided and the improvements made.

Staff had recorded people's compliments in a compliments file. One person's family member had been recorded as stating "The home is lovely, it feels different, they said we are doing a great job, everyone seems happy". Another relative was noted to have telephoned the interim manager to report "The home improvements in décor and care have massively improved in the past few months".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2019, a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. This was because the governance systems in place to ensure the service was well-led were ineffective. At this inspection, we found that although improvements to the service had been made, some of the governance arrangements at the home remained ineffective. This meant the provider continued to be in breach of regulation 17 at this inspection.

The provider had ensured that the systems in place to identify and investigate safeguarding incidents were improved upon. CQC however had not always been notified of safeguarding events in accordance with the provider's legal duties. It is important for providers to notify the Commission so that we are kept informed and aware of any issues or concerns about the service. We saw that a safeguarding audit completed in December 2018 failed to identify that the notification process to CQC was not always robust. This meant that the audit process in place was ineffective.

During our inspection we found serious concerns with the way medicines were managed. The stock of medication in the home could not be accounted for. It was impossible to tell if people's medications had been administered correctly and there was surplus stock in the home that had not been returned to the pharmacy in accordance with best practice. Despite these issues, the provider's medication audits all stated that there were no concerns with regards to people's medication. This did not demonstrate that the audit was effective in identifying areas of concern.

We saw that a staff meeting had taken place on the 28 January 2019. The minutes of this meeting noted that a concerns about the way in which medicines were managed at the home had been identified. Despite this, no effective action had been taken to address this and during our inspection, over a week later we identified similar and additional concerns.

There was a lack of consistent care plan audits undertaken to ensure that people's care plans were up to date and consistent. This meant that the issues we identified during the inspection with regards to some of the information in people's files about their needs and care being contradictory had not been addressed.

The provider had failed to address the outstanding safety certificate for the home's maintenance and at this inspection had to be reminded by inspectors to undertaken this once again.

This evidence demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw that a relatives meeting had taken place in December 2018 but found that no action had been taken to assess and monitor the opinion of the people who actually lived at the home with regards to the support. We saw that people who lived at the home had been involved in picking the new colour scheme and décor of the lounge and other communal areas in October 2018". There was a suggestion box for people to use

and also a 'You said, we did' notice displayed in the home that showed what action the provider had taken in response to people's suggestions about the service. This showed the beginning of good practice with regards to seeking and responding to people's feedback.

We were told by the assistant manager that staff no longer completed records on behalf of other staff members. The records we looked at were better maintained and contained greater detail than before. This was an improvement from the last inspection.

During our visit we found that the standards of cleanliness, infection control and maintenance of the home were much improved. The home was clean, day to day maintenance issues were addressed, new flooring and furnishings had been purchased and a new boiler installed. This showed that the provider had taken appropriate managerial action to address the majority of our environmental concerns identified at the last inspection.

We found the interim manager to have a responsive and positive attitude to improving the service. It was clear they had worked hard to improve the service despite only being in post for four months prior to our inspection. It was also obvious that with less people living in the home and the same number of staff on duty, people's support was much more effective and person centred than before. We recommend that the provider reviews staffing levels again should people's needs change or the number of people living in the home increases in order to ensure that the level of support observed at this inspection is maintained.

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 12 HSCA RA Regulations 2014 Safe care and treatment Some risks to people's health and welfare risks had not been properly followed up or addressed. Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and mitigate the risks to people's the health, safety and welfare were not always effective.