The Cheshire Residential Homes Trust

Trepassey Residential Home

Inspection report

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Heswall
Wirral
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
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**

Overall summary

Trepassey Residential Home provides personal care and accommodation for up to 24 people. Nursing care is not provided. The home is a detached three storey building in Heswall, Wirral. A small car park and garden are available within the grounds. There are twenty four single bedrooms with ensuite toilet facilities. There are also communal bathrooms on each floor. A passenger lift enables access to bedrooms located on upper floors for people with mobility issues and specialised bathing facilities are available. On the ground floor, there are two communal lounges and a dining room for people to use.

The home 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.'

We reviewed four care records. Some risks associated with people's personal care were assessed and managed. We found that some people's risks in relation to skin integrity, behavioural needs and some physical health conditions were not properly assessed and managed.

Summary of findings

This meant staff had no clear guidance on how to manage these conditions to prevent further decline. These incidences were a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations as people's plans of care did not fully meet their needs or risks so that safe and appropriate care was provided.

Where people had mental health issues, care plans lacked adequate information on how this impacted on their day to day lives and decision making. There was also little guidance for staff on how to support people's mental well-being. This was a breach of Regulation 11 of the Health and Social Care Act 2014 Regulations as people's right to consent had not been considered in accordance with the Mental Capacity Act 2005.

The care plans we looked at lacked person centred information. Person centred information enables staff to understand the person they are caring for so that personalised support can be provided. For example, staff had no information on people's preferences in day to day living. This made it difficult for staff to know how to respect them. Care plans contained no information on the possible causes or solutions to people's emotional distress or challenging behaviours. This meant staff had little guidance on how to support the person appropriately and in a person centred way when distress or challenging behaviours were exhibited.

People who lived at the home said they were happy and well looked after. They said they were treated with dignity and respect and had choices in how they lived their lives at the home. We saw that people had access to sufficient quantities of nutritious food and drink and were given suitable menu choices at each mealtime.

During our visit, we observed that staff treated people kindly and supported them at their own pace. People looked relaxed and comfortable with staff. From our observations it was clear that staff knew people well and had the skills and knowledge to care for them. We saw however that staff were often too busy tending to people's personal needs and other tasks, to have time to just sit and chat with people on a social level. An activities co-ordinator was employed at the home and provided a range of activities for people to join in with.

Staff at the home were recruited safely and received regular training and support in the workplace. Staffing levels were adequate and people's support needs were responded to promptly.

People told us they felt safe at the home and they had no worries or concerns. The home had a safeguarding procedure in place and staff received safeguarding training. We looked at the provider's safeguarding records. We found that some safeguarding incidents had not been appropriately reported to the Care Quality Commission in accordance with legal requirements.

People were provided with information about the service and life at the home. There was a complaints policy and procedure in place and it was displayed within the home. People we spoke with said they had no complaints about the service. We reviewed the provider's policy and saw that it did not contain the contact details of the organisations people could contact in the event of a complaint. This meant people at the home lacked sufficient information about who they should contact in the event of a complaint being made. We reviewed a sample of complaint records and saw that the manager had responded to these complaints appropriately.

Equipment was properly serviced and maintained and the premises were safe. The home was clean, free from offensive odours and well maintained. There were sufficient supplies of personal and protective equipment around the home which promoted good infection control standards.

The arrangements and information in place to assist staff and emergency services personnel in the event of a fire or other emergency evacuation required review to ensure it was up to date, safe and did not place people or staff at risk of harm.

There were quality assurance systems in place to assess the quality and safety of the service but some of these systems were ineffective. We also found that some of the provider's policies and procedures, designed to ensure safe and appropriate care, were not being followed. This impacted on the quality of the service and demonstrated that managerial improvements were required.

We saw there were regular opportunities for people to express their views about the home. The manager organised regular resident meetings and ensured that the provider's annual satisfaction survey was sent out to

Summary of findings

people each year. We saw that the survey and people's feedback was analysed to enable the provider to come to an informed view of the standard of service provided. People's feedback was also displayed openly at the home for people who lived there and visitors to the service to see.

Summary of findings

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 always safe.

People told us they felt safe and had no worries or concerns. There was a safeguarding policy in place and staff had received safeguarding training.

Not all of people's needs and risks had been properly assessed and managed. This placed people at risk of unsafe and inappropriate care. .

Staff were recruited safely and staff levels were sufficient.

The storage of medication and the arrangements in place for people to self administer their medication were not entirely safe

The premises and its equipment was safe and properly maintained. The provider's fire evacuation procedure was out of date and unsafe.

Is the service effective?

Requires improvement

The service was generally effective but required improvement in one area relating to the Mental Capacity Act (2005).

People said they were well looked after. It was clear from our observations that staff knew people well and had the skills and knowledge to care for them.

People were given enough to eat and drink and were given a choice of suitable nutritious foods to meet their dietary needs. Meals were served in a relaxed homely atmosphere.

People had prompt access to their GPs and access to other healthcare professionals as and when required.

The care plans for people who had mental health needs did not adequately describe how this impacted on their day to day lives. People's right to consent or right to refuse consent in accordance with the Mental Capacity Act (2005) had not always been respected.

Is the service caring?

Requires improvement

The service was not consistently caring.

People we spoke with held staff in high regard. Staff were observed to be kind and respectful when people required support. People said they had a choice in how they lived their lives at the home

We saw that support interactions between people and staff were pleasant and people appeared relaxed and comfortable with staff. We found however that staff focused mainly on completing tasks rather than engaging with people who lived at the home.

Summary of findings

People's end of life care had not always been discussed with the person to ensure their preferences were respected.

People were given appropriate information about the home but information on who people should contact in the event of a complaint required improvement.

Is the service responsive?

Requires improvement

The service was not always responsive

People's care plans lacked person centred information. People's emotional needs were not properly assessed and managed. Staff had little guidance on how to provide person centred support to people when they became distressed.

Records showed that staff at the home responded quickly when people became unwell and people received care from a range of health and social care professionals.

A range of social activities was provided by an activities co-ordinator.

People who lived at the home, relatives and the health and social care professional we spoke with had no complaint. The majority of complaints received had been handled in a timely and appropriate manner.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The home had an open, inclusive culture. Staff worked well together as a team and had a good relationship with the management team. This demonstrated elements of good leadership.

Quality assurance systems were in place to monitor the quality of the service. Some of these systems were however ineffective. This impacted on the quality of the service provided.

People were given regular opportunities to express their views about the quality of the service.

Trepassey Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 November and 1 December 2015. The first day of the inspection was unannounced. The inspection was carried out by an Adult Social Care (ASC) Inspector. Prior to our visit we looked at any information we had received about the home.

On the day of the inspection we spoke with six people who lived at the home, two care staff, two catering staff, the deputy manager and the registered manager. We also spoke with one social care professional.

We looked at the communal areas shared by people who lived at the home and a number of individual bedrooms. We reviewed a range of records including three care records, medication records, staff records, policies and procedures, records relating to health and safety and records relating to the quality checks undertaken by the manager.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with said that they felt safe at the home. People's comments included "Treated well"; "They (staff) are all nice, all polite" and staff "Are nice. It's very nice (here)".

We saw that the provider had a policy and procedure in place for identifying and reporting potential safeguarding incidents. We spoke to one member of care staff about identifying and responding to allegations of safeguarding nature. The staff member we spoke with did not demonstrate a full understanding of potential types of abuse. This meant there was a risk they may not be able to spot signs of abuse if they occurred. They did however understand the correct procedure to follow when responding to and reporting potential abuse and demonstrated a positive commitment to ensuring people were protected.

We saw that there were two incidents of a safeguarding nature that had not been appropriately documented or reported to the Care Quality Commission. We spoke to the manager about this, who acknowledged this had not been done in accordance with legal requirements.

Accidents and incident records showed that staff had responded appropriately to any accidents or incidents that had occurred and had ensured people received the medical help they needed.

We looked at the care plans belonging to four people who lived at the home. One person whose care file we looked at had not had any of their needs and risks properly assessed on admission to the home. This placed the person at risk of unsafe and inappropriate care. We saw from the person's daily care notes that the person's needs and risks were significant. We spoke to both the deputy manager and manager about this and they acknowledged that the person's care had not been properly assessed and managed. We saw that the inadequacy in the planning and delivery of this person's care had been picked up by social services, a week earlier. Despite this, a full assessment of this person's needs had still not been undertaken. This meant there was a risk that safe and appropriate care would not be provided to meet this person's health and welfare needs.

In the other care files we looked at, we saw that some of the risks in relation to people's health and welfare had been assessed for example, risks in relation to malnutrition, falls, dependency and moving and handling including the use of moving and handling equipment but other risks specific to the individual had not.

For example, one person's daily notes indicated they had a physical health condition that impacted on their ability to breathe. They attended regular outpatient appointments at the hospital for this condition. The risk of this physical health condition had not been assessed and the person's care plan made no reference to this condition. This meant staff had no information on what this condition was, the support the person required in relation to this or the signs and symptoms to spot in the event of associated ill health.

Two people had skin integrity issues that made them susceptible to pressure ulcers. We saw that they had regular visits from the district nurse team in relation to their skin. No assessment of the risk of pressure ulcers developing had been undertaken by staff at the home and there was no care plan guidance in place to mitigate the risks. This meant there was no guidance to staff on how to prevent or identify further skin deterioration.

Two people had mental health issues that meant at times they displayed challenging behaviours. These behaviours were documented in people's daily notes. There was no evidence this behaviour had been properly assessed and monitored to protect the person and others from avoidable harm. For example, there no evidence that any potential triggers or solutions to these behaviours had been explored to alleviate the person's distress. This placed people at risk of inappropriate or unsafe care. We spoke to the deputy manager about this who confirmed that no assessment or proper monitoring of these risks was currently undertaken.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations as people's plan of care did not fully meet their needs or manage risks to their health and welfare.

We saw that the majority of people's prescribed medication was stored securely in a locked medication room but some medicines, for example prescribed creams, eye drops and inhaler medication was found in people's bedrooms.

We saw that people had lockable medicine cabinets in their room but medication on the day of our visit was not stored in these facilities. One person told us that they did

not have a key to the medication cabinet to enable them to use it. This meant that these medications were not stored securely and were at risk of unauthorised use by staff, visitors or other service users who lived at the home.

On both days of our inspection, we saw that one person had eye drop medication in their room that required refrigeration in order for it to remain safe to use. This medicine was not stored safely.

We reviewed the home's medication policies and saw that people's capacity and capability to self-administer their medication was to be assessed prior to authorisation for medication to be stored in their own bedrooms. We asked the deputy manager if any of the people whose bedrooms we had found prescribed medication or creams in, self–administered their own medication. The deputy manager told that some of the people self- administered. We looked at two people's risk assessment in relation to self-administration and found them to be inadequate. The risk assessment did not assess the type or level of risk posed by self-administration in respect of the individual in order to determine if the person was safe to do so.

One person had anti-inflammatory medication in their room. We checked the person's care file and saw that there was no evidence the person had been assessed as safe to self-administer this medication. The deputy manager confirmed no risk assessment had been completed. We found there was no reference made to this medication being in used in the person's care file. This meant there was no information as to what the medication was for or why it had been prescribed. We asked the deputy manager about this, who told us it was to be used 'as and when required' to assist the person with pain relief for a physical health condition.

We checked the medication's prescribed instructions and saw that the medication had a dosage interval of not more than once in any four hour period. Despite this, there was no specific administration plan in place to guide staff how and when to administer this medication or how to do so safely. We saw from the person's daily notes that staff had administered this medication in November 2015 without this guidance. This placed the person at risk of unsafe use.

Other people had medication care plans that stated prescribed medication was to be administered by senior care staff yet prescribed medications were found in their bedrooms. For example, one person was found to have two bottles of prescribed creams and an inhaler in their bedroom but their care plan stated their medication was to be administered by senior care staff.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable systems in place to ensure the proper and safe management of all medicines in the home.

We saw that staff had received training in the safe administration of medication and had their competency checked. We checked a sample of five people's medication administration records (MAR) against medication stock levels to ensure they matched. We found that people's medication records were accurate and matched what had been administered.

People we spoke with thought the premises were well maintained. On the day of our visit, we found the home was clean, warm and of a good standard. The gardens were tidy and well looked after. We saw that the provider had been awarded a five star rating by Environmental Health in June 2014 for its standards of food hygiene. A five star rating is very good. We saw that the kitchen was well organised and managed.

We checked safety certificates in relation to the heating, electrics, fire and moving and handling equipment. They all conformed with recognised safety standards and were regularly inspected and serviced by external contractors.

There was an up to date fire risk assessment in place to mitigate the risk of a potential fire. The provider's fire evacuation procedure however was inadequate. It did not provide clear or safe guidance to staff on what to do in an emergency evacuation and if followed would have placed staff at risk. When we asked the manager how people who lived at the home would be protected from harm during a fire, the manager was unable to describe the evacuation procedure staff would follow. The manager acknowledged the procedure was out of date and told us they would review it without delay.

People's personal emergency evacuation information was found in the manager's office. This type of information is designed to give staff and emergency services immediately accessible information each person's individual needs and

risks in the event of an evacuation. This information was not up to date. Some of the people who currently lived at the home had not been included. We spoke to the manager about this who said they would update the information.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable procedures in place to do all that is reasonably practicable to mitigate the risks associated with fire in order to protect people from risk.

We saw that antibacterial soap and alcohol hand gels were available throughout the home to assist with infection control. The home was adequately clean and there was ample protective personal equipment for staff to use in the delivery of personal care.

We looked at three staff files. All the files we looked at demonstrated that the necessary checks were undertaken to ensure that staff employed were of good character and suitable to work with vulnerable adults. We saw in some of the files we looked at that the staff member's criminal conviction check had not been renewed periodically to ensure that staff remained suitable to work with vulnerable people. This meant that there was a risk that this information was out of date. We spoke to the manager about this.

The deputy manager told us that during the day three care staff were on duty including the deputy manager and the manager. At night, there were two members of staff on duty to support people's needs. The staff rota's we looked at confirmed this. We saw that people's level of dependency was assessed on admission to the home and regularly reviewed. The deputy manager told us that the majority of people at the home required the support of one carer only at any one time. They said that they were currently using agency staff on a regular basis whilst they were in the process of recruiting new staff. They told us that they used the same agency and where possible the same agency staff to cover staff shortages so that agency staff were familiar with people's needs.

People we spoke with said there was enough staff on duty to meet their needs. We observed that staffing levels were adequate and that people's support needs were met promptly.

Requires improvement

Is the service effective?

Our findings

All of the people we spoke with told us the care was good and that staff cared for them well. People's comments included "Staff are exceptional, consistent and good staff; "We get well looked after" and "Staff are perfect".

We spoke with the deputy manager, manager and two care staff about the people they cared for. Staff we spoke with demonstrated an understanding of people's needs and spoke warmly about the people they cared for.

Staff told us they felt supported in their job role and they received regular supervision and appraisal. Records in relation to established staff confirmed this. Two of the staff files we looked at, related to two new members of staff who had been employed at the home for less than 12 months. We could find no evidence in these files that these new staff had received appropriate support and supervision during their first few months of employment.

We asked the manager if these two staff members had received formal supervision since their appointment. The manager confirmed no supervisory meetings had taken place. This meant that no checks had been made on the new staff member's progress or development needs in order to ensure they had the skills and knowledge to care for people effectively.

Staff training records showed that staff had access to regular training opportunities in topics relevant to the needs of people they cared for. For example, training was provided in health and safety; first aid; moving and handling; dementia, deprivation of liberty safeguards; dementia, safeguarding; food hygiene, the administration of medication and infection control.

We saw staff throughout the day, verbally checking people consented to the support they were given. After lunch on the second day of the inspection, we chatted to a person who was sat in the entrance area of the home. This person they told us they would like to go to their bedroom but that staff would not let them. We asked a staff member about this. They told us they were frightened of the person falling in their bedroom so they had not been taken up to their room. This meant that the person's wish to spend time in their own private space and their right to control where they spent their time during the day was not respected.

The Mental Capacity Acts 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do 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 checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

We found that care plans for people living with dementia or short term memory loss lacked sufficient information about how these conditions impacted on the person's day to day life and their ability to consent to any care and treatment decisions made. No capacity assessments had been undertaken and no deprivation of liberty applications had been made or granted in respect of anyone who lived at the home. Despite this we found that some people were unable to leave the home of their own free will.

For example, one person had short term memory loss. There was no information in the person's care file to indicate the person lacked capacity to make any decisions. We asked the deputy manager and manager about this. They told us that the person did not lack capacity to make decisions about their care and welfare themselves. We saw from their care records that the person was for the majority independent in respect of their care needs and that they had discussed and consented to their own plan of care. The person had also been involved in and consented to a decision relating to cardio pulmonary resuscitation in conjunction with their doctor. This evidence suggested that the person had the ability to discuss and consent to their own decisions.

The person's daily records indicated periods of agitation associated with not being able to go outside as they pleased. We saw that this person's care plan instructed staff to ensure the person was supervised when they left the home. We asked the manager about this who told us the

Is the service effective?

person could go into the garden of the home unsupervised but they could not leave the grounds alone as they were not safe to do so. The manager confirmed no capacity assessment had been completed in relation to their ability to keep themselves safe outside of the home. This meant there was no evidence to indicate that the person was not able to maintain their own safety on leaving the grounds of the home. No consideration had been given by the manager or provider as to whether this constituted an unlawful deprivation of the person's liberty.

These examples are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that there were suitable arrangements in place to ensure people's human rights were respected.

People we spoke with told us the food was good. They said they were always offered an alternative if they did not like the food on offer. They told us staff checked at mealtimes that they had had enough to eat and drink. They said additional portions were always offered. One person said "The food is very good. It's not always what I like but they give me an alternative".

We observed the serving of the lunchtime meal and saw that the meal was served promptly and pleasantly by staff. The dining room was light, airy and the lunchtime meal was served in a relaxed atmosphere. There was one choice on offer for lunch on both days of our visit. We observed staff offer one person who told them they did not like the menu choice on offer, a range of suitable alternatives. The food provided was of sufficient quantity and looked and smelled appetising.

We reviewed three care files and saw that people's nutritional needs were assessed. Records showed people were weighed monthly and their weights monitored to ensure they remained safe.

Where people were at risk of malnutrition, referrals to dietary services had been made and people had access to prescribed supplements. Where people required assistance to eat, we saw that the type of support they needed was documented within their care records for staff to follow.

People who lived at the home and their relatives told us that they had access to their GP as and when needed. People's daily notes showed that staff monitored people's health and wellbeing on a daily basis and responded appropriately when people became unwell. Records showed that people had prompt access to specialist support services as and when required and people's health needs were followed up promptly and acted upon where required.

We saw that there was a range of comfortable seating areas in and around the home to enable people to choose where and with whom they sat. There were three communal areas were people tended to congregate, the entrance area of the home and two lounges. Décor was traditional and pleasant but not particularly conducive to promoting the independence of people living with dementia who require environmental cues to enable them to find their way around their home.

For example, the décor was a plain colour with no contrasting colours to enable people living with dementia to orientate themselves to their environment. Communal bathrooms were mostly white which made it difficult for people living with dementia to distinguish one surface from another and although people's bedroom names were on their doors, the name plates were small, above eye level with no distinguishing features to assist the person to recognise their own bedroom.

Requires improvement

Is the service caring?

Our findings

We asked people if staff treated them well. People said that they did. Their feedback included "It's very nice here"; "Staff are nice they look after us"; Without exception, I can't fault the nursing staff" and the staff are "Very kind and caring".

We saw that some people sat together during the day in companionship. The home had a warm, homely atmosphere and staff were respectful and polite at all times. People we spoke with told us that they felt staff knew them well. People were well dressed and looked well cared for.

We observed staff supporting people who lived at the home throughout the day. It was obvious that people felt comfortable with staff and that staff were familiar with their needs. Interactions between people who lived at the home and staff were positive and pleasant. Staff were courteous, addressed people by their preferred name and displayed positive body language in all interactions. They were observed to be responsive when people required assistance. They supported people at their own pace in a dignified manner and ensured people's needs were met.

When asked, people said they thought staff helped them to remain independent with their personal care wherever possible. We saw some evidence in people's care files that people's ability to self -care was supported wherever possible.

As we looked around the home, we saw that people's laundry including nightwear and underwear was popped over the handrails around the home. This made it difficult for the handrails to be used by people to mobilise but also did not promote people's privacy and dignity. At lunchtime, a brass bell was rang to call people to the dining room. This sounded like a school bell and did not promote the reality that this was people's home.

We looked at how the home ensured people's end of life wishes were identified and respected. There was evidence in only one of the four files we looked at that end of life discussions had taken place with people and their relatives.

For example, one person had a do not resuscitate record in their file but there was no information recorded in respect of the person's future care preferences and two people did not have any end of life information or future care wishes noted at all. We spoke to the manager about this. They said that this type of conversation was difficult to have with people and some people did not want to discuss this. There was no record in any of the files we looked at, that people had been given the opportunity to have this discussion and opted not to.

We noted that the majority people had a decision relating to cardio pulmonary resuscitation on their file which indicated that decisions relating to their end of life care had been discussed with their doctor. This meant there had been an opportunity for staff to have discussions with people about their future wishes when these decisions were made.

We looked at the daily written records that corresponded to the care records we had seen. Daily records showed that people had received care and support in relation to their personal care and that staff monitored their general well-being.

The home had a service user guide for people to refer to. We looked at the information provided and saw that it included information about the home and the services provided.

Minutes of the last resident meeting to take place were available in the entrance area of the home for people to review. We reviewed the minutes and found that people had been provided with information about the running of the home, future plans that affected their care and that people had been asked for their feedback and suggestions on recent and future social activities. This showed us that people were given appropriate information in relation to their care and were able to express their views about the quality of the care provided.

Requires improvement

Is the service responsive?

Our findings

People we spoke with told us that staff were responsive to their needs. One person told us that staff had responded quickly to signs of ill health and ensured they received the medication they needed. They told us that the manager came to see them routinely each week to check that they were okay. Another person told us they "Had no qualms about anything" and that "When I want help with anything, I know I will get it".

We looked at four care files. From the records we could see that people's health needs were responded to promptly. Referrals to specialist services had been made as and when required. For example, referrals to dietary services, falls team, continence team, mental health support and specialist outpatient clinics had been supported. Records showed that the person's doctor was contacted appropriately when they became unwell with any advice given by the doctor documented in the person's care file on a professional visit record form. People's care plans however had not been consistently updated with this information. This meant there was a risk that some staff may not be aware of this information.

Personal life histories are designed to capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person living with dementia.

In all four files we looked at, care plans lacked person centred information. For example, information about people's care preferences, preferred daily routines and dietary likes and dislikes was not recorded. This meant it was difficult to tell if the person had been involved in the planning of their care and if so, what choices they had made. Only one of the care file we looked at contained a personal life history and this was focused primarily on the person's occupational background. We spoke to the deputy manager about this. They told us they often asked the family of the person to complete a personal life history with the person but a lot of the time the family took a long time to return this information. This meant that an opportunity for staff to sit with and really get to know the person well was missed and this information was not available when care was planned to ensure it was person centred.

We saw that people who needed support with their mental health needs had the appropriate support from local mental health teams. Where people had behaviours that challenged, care plans failed to provide any person centred guidance to staff on how to support the person to alleviate their distress or enable them to communicate their needs in a more constructive way. This placed people at risk of receiving care that did not meet their needs or preferences.

We asked one staff member how they responded to one person's episodes of challenging behaviour. Although they demonstrated a kind and understanding approach, they could not tell us what specific support they gave to this person during these episodes to alleviate their distress.

Where professional mental health advice had been given, we saw that this advice had been documented in the person's record of professional visits but had not been included in the person's plan of care. This meant there was a risk that staff may not be aware of this information and its importance in caring for the person.

These examples are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not done everything reasonably practicable to make sure that people who lived at the home received personalised care that met their needs.

People we spoke with confirmed activities were on offer at the home. One person felt that the home could do with more activities. We saw that a poster advertising the activities available at the home was displayed in the entrance area. The activities advertised included a sherry party, pianist evening, Jack and the Beanstalk pantomime trip, Active Minds session and Holy Communion.

During our visit, we saw that staff were too often busy completing tasks such as serving lunch and sorting out the laundry to have a proper opportunity to engage people in general conversation. One person told us they felt lonely at the home as no-one talked to them. We saw that this person was often sat in the communal entrance area of the home on their own.

On the first day we visited, the activities co-ordinator was putting up the Christmas decorations. This activity would have been an excellent activity for people to be engaged with but no-one at the home helped. We did not see any concerted efforts made by staff to encourage people to join

Requires improvement

Is the service responsive?

in to help. On the second day of our visit, a reading session took place in one of the lounges which some people attended and some people had gone with staff for a Christmas Pub Lunch.

People we spoke with said they knew how to make a complaint but had no worries or concerns. We looked at the provider's complaints procedure and saw that it was easy to understand with timescales for the acknowledgement, investigation and response to any complaints made. Contact details for who people could contact in the event of a complaint were however not provided.

For example, no contact details were provided for the manager of the home, the Trustees or Trust Administrator, the Local Authority or the Local Government Ombudsman. This meant people may not know who to direct to their complaint to in the first instance, or which external bodies to escalate their complaint with, should they be dissatisfied with the manager or provider's response to their complaint in the first instance.

We looked at the provider's complaint records and saw four complaints had been received since our last inspection. We reviewed these complaints and saw that the provider had investigated and responded appropriately to the majority complaints in a timely manner. We found that one complaint had not been documented and we spoke to both the manager and deputy manager about this.

Requires improvement

Is the service well-led?

Our findings

During our visit we found the culture of the home to be positive and inclusive. Staff were friendly, welcoming and hospitable to visitors. They were observed to have good relations with each other and were warm and pleasant in all their interactions with people at the home. We found that staff had a positive work ethic and were confident in the management of the home. This demonstrated good staff leadership. Improvements were required however in how the provider and manager monitored the quality and safety of the service.

We saw that the provider undertook a range of monthly audits which included care file audits, safeguarding and complaint audits, monthly medication audits, equipment checks and environmental audits. We found that some of these audits were ineffective.

During our visit we found there was a lack of suitable arrangements to ensure people's needs were accurately care planned and risk assessed. All of the care records we looked at contained gaps in risk assessment and care plan information. This meant that the provider's care file audits failed to be effective in ensuring the information about people's needs was adequate to meet their needs and risks. We also saw that where the audits had picked up issues within care records, the audit was not effective in ensuring any improvements were sustained.

For example, several of the care file audits we looked at noted that personal inventories relating to people's belongings had not been completed on admission to the home. On the day of our inspection, we saw that one of the four care files we looked at contained the person's personal inventory scribbled on scrap pieces of paper, held loosely in their file. The proper paperwork had not been completed on admission and the person had been living at the home for over three weeks.

Policies and procedures in some instances were out of date or not followed by staff and the management team at the home. For example, the provider's medication policy clearly stated the procedure for staff to follow to ensure the safe self- administration of medication. From our observations and conversations with the management team during our visit, it was clear staff and the management team were not adhering to this policy. The provider's fire evacuation procedure was out of date and unsafe and the provider's mental capacity policy to ensure people's legal right to consent was protected had not been implemented.

The provider's safeguarding policy clearly stated safeguarding concerns would be reported appropriately to the Care Quality Commission (CQC) but this had not been consistently done. Accidents and incidents resulting in injuries or ill-health which resulted in a visit to the hospital were also not always reported appropriately to CQC in accordance with legal requirements.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) 2009 regulations as the provider must notify The Commission of all incidents that affect the health, safety and welfare of people who use the service.

The provider's audits designed to monitor safeguarding incidents and accident and incidents which occurred at the home, both failed to pick up that some of these incidents were not reported appropriately. This demonstrated these audits were ineffective.

When we spoke to the deputy manager and manager about their responsibility to notify The Commission of certain events, they did not demonstrate an awareness of their duty to do so.

Accident and incident audits were in place to identify and monitor people's consecutive falls. This enabled the manager to identify people who may require specialist support from the falls prevention team, occupational therapy and assistive technology services. The audits did not monitor trends in how, when or where accidents and incidents occurred. This would have enabled the provider to learn from and take preventative action where appropriate.

We reviewed how the provider monitored any complaints received. We found the provider did not have an effective system in place to log and monitor the type of complaints received in order to identify any potential trends. This meant the provider's system for analysing, learning from and preventing similar complaints from being received, was ineffective.

These examples demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Requires improvement

Is the service well-led?

Activities) Regulations 2014 because the provider failed to have effective systems and processes in place to assess and monitor the quality and safety of the service provided.

Regular equipment and environment audits were in place including safe water temperature checks to prevent scalding; mattress audits to ensure they were in a good state of repair and clean, bath hoist checks and an health and safety check that audited all areas of the home for potential risks. This meant that the provider had an effective system in place to assess and mitigate any potential risks to people's physical safety and wellbeing.

We saw that the manager compiled a monthly management report which was sent to the provider. This report gave the provider information on the management of the service. The report gave details of occupancy levels, changes/any concerns in people's health and well-being, staff changes, accident and incidents, hospital admissions and any complaints received.

We saw that the results of a recent satisfaction survey completed by people who lived at the home or their relatives were displayed in the communal entrance area of the home for people and visitors to the home to see. We also saw that regular resident meetings were undertaken to gain people's feedback and that these minutes were also publicly available in the entrance area. This showed us that the provider had systems in place to gain people's feedback on the quality of the service provided.

We saw that the satisfaction survey was completed in May 2015. 16 completed questionnaires had been completed by people who lived at the home or their relatives. The results of the survey were positive. They demonstrated that overall people who lived at the home and their relatives were satisfied with the quality of the service provided. People's survey comments about staff and the home included "This is a good home"; "Wonderful, kind staff, always cheerful and smiling" and "Management are always at hand to help".

We spoke to the deputy manager and the manager about the regulatory issues we found during our inspection. We found both to be open and receptive to our feedback.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's ability to consent to decisions about their care had not been fully considered in the planning or delivery of care in accordance with the Mental Capacity Act 2005. Regulation 11(1) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have sufficient systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who lived at the home. Regulation 17(2)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not ensured that all incidents that affect the health, safety and welfare of people who use the service were notified to The Commission appropriately. Regulation 18 of the Care Quality Commission (Registration) 2009

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 The planning and design of people's care did not assess or mitigate all of people's needs, preferences or risks, Fire arrangements at the home were inadequate and did not protect people and staff from risk. Regulation 12(1),(2)(a) and (b)of the Health and Social Care Act 2014 Regulations.

The enforcement action we took:
We have issued the provider and the manager with a Warning Notice. This will be followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have suitable systems in place to ensure the safe management and administration of medicines at the home. Regulation 12(2)(g) of the Health and Social Care Act 2014 Regulations.

The enforcement action we took:
We have issued the provider and the manager with a Warning Notice. This will be followed up and we will report on any action when it is complete.