

Conifers Care Homes Ltd

Oaklands Nursing Home

Inspection report

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20 November 2017

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

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 an inspection on the 16 and 20 November 2017. The first day was unannounced.

Oaklands nursing home 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.

Oaklands is located in Littleton on the outskirts of Chester. The home is a three storey building with access to all levels being provided by a passenger lift. There are 45 bedrooms; most have en-suite facilities. The home can provide care for up to 50 people.

The service has had a registered manager in post since April 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service has not been previously inspected by Care Quality Commission under the new inspection methodology. During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of the report.

Appropriate checks on visitors to the service were not always completed by staff to ensure people were safe in their home environment. We raised concerns to the management team regarding the safety and security of the building and asked them to address this with immediate effect.

Quality assurance systems in place were not always effective. Action plans had not always been put in place to address the improvements needed. There was a lack of management oversight to ensure that checks were carried out as required across the different areas of the service.

Supplementary records were not properly maintained to make sure they were accurate and fully complete. Care plans were not always personalised.

The management of medicines was safe. Records we viewed were completed appropriately and people told us they had received good support to take their prescribed medications. However, the registered provider's medication audit required improving. The audit did not clearly identify what actions had been taken to improve practice when medicines errors had occurred.

People told us and observations showed that they were offered choices at mealtimes and a variety of regular snacks and drinks throughout our visits. However, further improvements were required to improve the mealtime experience for people living at the service. We have made a recommendation to the registered provider.

Improvements were required in relation to the management of rotas. The registered provider's recruitment procedures were followed appropriately. All staff were subject to a range of checks to ensure that they were suitable and safe to work with vulnerable people.

Regular supervisions and team meetings had been recently re-introduced and staff confirmed that communication had started to improve at the service. People were supported by staff who had received appropriate training. All staff received training to enable them to fulfil their roles which included essential subjects such as moving and handling, safeguarding people and medication training.

Risk assessments were completed for each person supported, and identified any risks to their health and safety. Assessments provided information to guide staff on how to minimise risks to people and themselves when providing care and support.

Staff worked well with external health and social care professionals to make sure people received the care and support they needed. People were referred onto the appropriate service when concerns about their health or wellbeing were noted. Staff spoke kindly to people and respected their privacy and dignity. Staff knew people well and had a caring approach.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

All staff had completed safeguarding adults training and were able to describe different ways that people may experience abuse. Staff and managers had a good understanding of the procedures they were required to follow to ensure people protected from the risk of abuse. However, staff understanding of how to raise concerns through whistleblowing and who to contact was varied.

The management and oversight of accident and incidents was good. The registered manager evidenced where trends and patterns had been established and actions taken to mitigate any further risks to people supported.

There was an effective complaints system in place. People and staff knew who to raise concerns with and there was clear line of accountability amongst senior staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not consistently safe

Staff did not always seek clarity as to the identity of visitors to the service. This placed people at risk of harm.

The management of staff rotas required improvements to be made. People told us that they felt there were enough staff on duty.

The recruitment process was robust and appropriate pre-employment checks were completed.

Is the service effective?

Good 

The service was effective

People were provided with regular access to food and drink. However, the mealtime experience required improvements to be made.

The principles of the Mental Capacity Act 2005 (MCA) were embedded within the service. Staff understood the importance of seeking consent to care.

People were supported to access healthcare and specialist services when required in order to keep them well.

Is the service caring?

Good 

The service was caring.

We observed positive relationships between staff and people living at the service. Staff that supported people were kind and caring.

People were treated with dignity and people's privacy and choices were respected.

Staff promoted independence at all times. People were supported and encouraged to make their own choices and decisions and staff understood the importance of this.

Is the service responsive?

The service was not consistently responsive

Supplementary records were not always accurately completed.
Care plans were not always personalised.

People and relatives had access to the complaints procedure
and felt comfortable in raising concerns.

People had access to a good range of activities on a daily basis.

People were supported to express their wishes regarding end of
life care and support. Staff recognised the importance of their
role when providing end of life care.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Quality assurance audits were not effective. There was a lack of
oversight to ensure appropriate checks were completed as
required. Action plans were not robust.

Meetings were held with people in order to gain feedback about
the service they received.

CQC were notified about incidents that had occurred at the
service as required.

Requires Improvement ●

Oaklands Nursing 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 site visit took place on the 16 and 20 November 2017. Our inspection was unannounced on the first day and the inspection team consisted of one adult social care inspector and an expert by experience on the 16 November and two adult social care inspectors on the 20 November. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

We spoke with eleven people who used the service and four of their family members. We also spoke with nine members of staff, the registered manager and provider. We looked at the care records relating to eight people who used the service, which included, care plans, daily records and medication administration records. We observed interaction between people who received support and staff.

Some people at the service were living with dementia. This meant they were not always able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us

Prior to the inspection we reviewed the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including notifications of incidents that the registered provider sent us since the last inspection, including complaints and safeguarding information.

We contacted local commissioners of the service and Healthwatch. Healthwatch England is the national consumer champion in health and care and they have statutory powers to ensure the voice of the consumer

is strengthened and heard by those who commission, deliver and regulate health and care services. We also contacted a number of health professionals including tissue viability nurses and speech and language therapists who had previously visited the service, to obtain their views. No concerns were raised about practice at the service.

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "Yes I do feel safe here. They do their best for me and I can ask for anything and they will do it for me" and "I do feel safe because I know they are looking after me and if I ring my bell they get to me as soon as they can". Family members told us, "[My relative] feels much safer here than they did elsewhere and the staff are very good. I have no concerns about them being here and if they need anything the staff respond pretty quickly".

On arrival to the service on the 20 November, both inspectors were able to enter the service as staff had let them in through the front door. Staff did not ask either inspector for Identification or request information as to who we were visiting. After approximately ten minutes, during which three staff members had walked passed inspectors a member of the nursing team asked who we were waiting to see. We raised concerns immediately to the management team regarding the safety and security of the building and people supported. This occurred again during our feedback visit on the 27 November. This presented a safety risk for those people living at the service as staff did not undertake the necessary checks as to who was being let into the building.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as people's safety was not adequately protected and appropriate actions were not taken to mitigate risks.

Discussions with people and their family members confirmed that staff did their best to meet the needs of everyone supported. People told us, "Sometimes I think they could do with more staff because they are in a rush and they will be helping me and they have to go somewhere else because of an emergency" and "I ring my bell at 8 because that's when I like to get up and generally they are there on time for me". When asked, the registered manager provided inspectors with rotas up until week ending 19th November and informed us that the rotas for the following week were required to be written. This did not provide sufficient information relating to the safe levels of staffing required to manage the service and keep people safe from harm. During our visit on the 20 November 2017 we found that staffing levels were not in line with the registered providers assessed allocation. Communication regarding the shortage of staff was not clear between the registered manager and staff on duty. Rotas also showed a shortage of staff on a further three days. We raised this immediately to the attention of senior staff who during our visit ensured that all shifts were adequately covered. The completion of rotas was reviewed following our visit.

The provider had a policy in place for safeguarding people. This contained guidance on the action that would be taken in response to any concerns found. Records identified that training had been completed regarding safeguarding adults and children. Staff were able to describe how they would recognise signs of abuse and harm and were clear about how and who they would report concerns to within the management team. Staff understanding in relation to whistleblowing varied. Whistleblowing is where staff can raise any concerns inside or outside the organisations without fear of reprisals. We spoke with the registered manager and provider who advised they would undertake further training to ensure staff were confident in using this approach. Records evidenced that concerns were raised with the local authority and other agencies such as CQC where appropriate.

Accident and incident records had been completed as required when events had occurred at the service. Records evidenced incidents such as slips, trips and falls and any injuries sustained by people. Where people had experienced regular falls, the management team had undertaken an effective review and analysis of incidents. Action plans were in place to minimise the risk of further incidents occurring. This meant that people were appropriately protected from the risk of falls.

People told us, "I have medication at different times of the day and the staff make sure I get it on time" and "They help me with all sorts of pills and I get them on time and when I need them". Family members told us, "[My relative] has medicine for their skin and the staff help with applying that. They always make sure [my relatives] skin is kept in good condition".

Nursing staff had access to policies and procedures and codes of practice in relation to the safe management of medicines. Important information about people's medication, including what the medication was for and any possible side effects and any known allergies was kept within the medication records. Procedures were in place for the use of controlled drugs and appropriate records were kept of these medicines. Arrangements for the receipt, storage and disposal of medicines were in line with good practice and national guidance. Medication administration record sheets (MARs) we reviewed were properly completed and staff had used signatures and appropriate codes when completing them. A recent photograph of the person was in place which helped staff identify the person prior to administering medication. Observations showed that staff took time with people when administering medication and this ensured that people had the opportunity to understand what they were taking and to be involved in taking their medication.

The registered provider had recruitment and selection procedures in place. Information contained in staff files demonstrated that appropriate checks had been carried out prior to them starting their employment. For example, for four staff recruited since our last visit we saw that an application form had been completed, evidence of formal identification had been sought and written references had been obtained. In addition a check with the Disclosure and Barring Service (DBS) had been carried out. These checks were carried out to ensure that only staff of suitable character were employed by the registered provider.

Environmental risk assessments were in place to reduce risks to people living and working at the service. Appropriate checking and testing of equipment had been conducted. This ensured equipment was well maintained and safe for its intended purpose. This included safety testing of mobility aids and electrical equipment. Regular checks of the premises and environment were completed and actions taken were documented to any concerns identified. However, during our visit we identified that some cupboards containing equipment that may have posed a risk to people where not able to be locked. We spoke with staff on duty and these areas of risk were addressed immediately to ensure people were protected from the risk of harm.

Risks to people's health and safety were managed. People had an up to date individual evacuation plan showing the support they would need in an emergency situation. These were located in a 'grab and go' file located in the nurses station. Systems were in place to regularly test fire safety equipment such as emergency lighting, alarms and extinguishers. A fire drill had been undertaken by day staff earlier in the year. The registered provider confirmed that they would introduce fire drills during different times of the day and night to ensure safe practice. People's safety in the event of an emergency was supported.

The registered provider's business continuity plan outlined procedures for staff to follow in the event of an emergency. Examples included failure of electricity, gas, a disruption to the water supply or loss of accommodation. Staff knew where to locate this information and this contingency plan supported people

and staff to remain safe.

Infection control processes were in place to keep people safe. Infection control information was displayed around the service, including the registered providers infection policy and procedure. There were hand sanitizers and handwashing instructions displayed near to hand basins. There were plentiful supplies of personal protective equipment. Staff wore PPE for tasks such as handling soiled laundry and when assisting people with personal care. Laundry was handled and laundered in line with infection control procedures.

Is the service effective?

Our findings

People told us that they were supported (were required) to make decisions regarding their life. They said, "The staff make sure they consult me on anything to do with my life. They know how important that is to me" and "They always ask me first before they do anything to help me as they know my independence is very important. They are very respectful and don't presume". Family members told us, "They always consult with [my relative] about their care needs".

People told us, "I'm not a big eater, but I get plenty to eat and drink here. The staff always check to see if I need anything" and "The food is ok, although sometimes by the time it arrives it's lukewarm. I have mentioned it and the staff have tried their best to improve matters". People had food that they liked to eat and were supported to have a balanced diet. People had been consulted about their likes and dislikes, allergies and any specific medical dietary needs. Information regarding these areas was recorded, up to date and available in the kitchen for staff to follow when preparing meals. People were involved in choosing their own meals on a daily basis and the chef regularly visited people for feedback. Observations confirmed that if someone didn't like the meal or if it wasn't the correct texture for them to eat they had a separate suitable meal for their taste. People had their nutritional needs met by the service.

However, the mealtime experience was disorganised and in need of review. For those people living with dementia there were no visual aids to assist with the understanding that it was mealtime. Tables were not set in a timely manner and condiments and cutlery were only made available to people shortly before their meal arrived. The dining room was overcrowded and people were left sitting at dining tables for over 30 minutes waiting for lunch to be served. Comments shared by people waiting included, 'Why are we waiting here?', 'What's taking so long. I thought lunch was ready' and 'I am off in a minute, this is taking ages'. Staff were reassuring people by explaining that it was lunchtime and food was going to be served soon, but some people started to get frustrated with each other.

Staff were seen to be serving meals to a number of people both in the dining room and lounge area. There was a system in place that enabled staff to check and ensure that those people who chose to eat in their bedrooms received regular access to food and drink. People who required assistance did get the level of support they needed but there was an inconsistent approach from staff. We raised this with the registered manager and provider who told us that they recognised further improvements were required in relation to the mealtime experience at the service.

We recommend that the registered provider refers to best practise guidance on positive mealtime experience including for people living with dementia.

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

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and DoLS. Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, the impact of refusing treatment or how to keep themselves safe. Care plans contained evidence of 'decision specific' mental capacity assessments (where required). These were with regards to support tasks such as medication, personal care, diet and nutrition. Best interest meeting records outlined further discussions that had taken place with relevant others, where people had been assessed as lacking capacity to make a specific decision. Staff recognised where and when it was appropriate to involve other professionals such as advocates and IMCA's to support people with decision making.

The manager demonstrated that applications had been made to the local authority on behalf of people in relation to Deprivation of Liberty Safeguard (DoLS) authorisations.

People told us, "They staff are definitely trained. They are very good at what they do" and "Most of the staff are very good and I think the quality of the nurses is ok too". Family members told us, "[My relative] has confidence in the staff and their ability. They seem very clear on what they need to know and do to help people". Training records showed staff had completed a range of training relevant to their roles and responsibilities. New staff within the service completed a comprehensive induction programme before they were permitted to work unsupervised. One staff member confirmed that they had received a mix of online, face to face training and competency assessments that had provided them with lots of new skills. New staff had also started working towards the care certificate. This is awarded to staff new to care work who complete a learning programme designed to enable them to provide safe and compassionate care.

Supervisions for nursing staff provided opportunities for them to discuss their performance, development and training needs. One staff member said, "I find my supervisions are a chance for me to raise any concerns or discuss where things are going well". However, we noted that supervisions for care staff were not kept up to date and staff confirmed that they had been infrequent. The management team had recently introduced a new system of allocation to address this and to ensure that each staff member had the opportunity to meet with the registered or deputy manager on a 1:1 basis to discuss their performance.

People were supported with all medical appointments. They told us, "If I need to see a doctor, the staff will organise a visit for me as soon as the doctor is available" and "I get access to healthcare when I need it. The staff seem to know who the best person is to contact". When people's health needs changed or they became unwell we saw that the registered manager and staff took action to gain the healthcare support they required. Records and discussions evidenced that staff consulted with specialist healthcare professionals such as doctors, tissue viability nurses or dieticians when needed. Health professionals informed us that they had good working relationships with staff at the service and had confidence in their ability to identify and raise any concerns with people's health.

People told us, "It is a lovely environment here. It's quite homely really and I have my own personal items around me which is lovely". People lived in a service that was well maintained. Bedrooms were clean, warm and people had their own belongings in place to create a personalised environment. The registered manager discussed how adaptations had been and were still in the process of being made to improve the environment for people living at the service. A discussion was held with the registered manager and provider in relation to the introduction of dementia friendly signage to support wayfinding within the service. They confirmed that they would review this in the near future.

Is the service caring?

Our findings

Observations showed that people felt very comfortable with the staff and there was a calm atmosphere at the service. One person told us, "I think that I'm very well cared for here and the staff who look after me treat me with respect". Another person told us, "At my age I'm not bothered that I need a bit of help to wash and dress. All I can say is that they are very proper with me, I have no concerns at all". Family members commented, "They treat [my relative] well. They have never complained about anything and always tell me that the carers are lovely".

People were encouraged and supported to make decisions and choices about all aspects of their care, and their choices were respected. Staff involved and supported people in making decisions about their personal care and support. Family members confirmed that, where appropriate, they were involved in their relatives care planning and were kept well-informed of any changes.

People were able to tell staff how they were feeling and staff responded in a supportive way. One person shared with us how they had felt a little bit 'down' when they had moved into the service. They explained how staff had taken the time to make sure they had someone to talk too and introduced them to other people living at the service so they were not lonely. The person commented how this had helped them to adapt and settle better to the change in their living arrangements.

Staff knew people's cultural and religious backgrounds. People were supported to access a culturally appropriate service and maintain their faith where required. One person told us, "I chose this service to live in as I know that they have a history of respecting and promote people's faith. That was a very important part of my decision making. I have not been disappointed".

The registered provider's statement of purpose outlined that people living at the service would be treated with respect, dignity and individuality. People told us, "I need a hoist to support me to get out of bed and staff help me wash and dress and go to the toilet. I tell them what I want and I think I'm probably a bit bossy but they always do as I ask. Most are very good" and "The ladies and gentlemen who look after me have got to know me now and everything is fine. They know my preferences and routines; it's all clicked into place".

People's privacy was respected. Personal care was carried out privately and discreetly and staff ensured that people's dignity was promoted at all times. Staff closed doors when they provided people with personal care and they knocked on doors prior to entering bathrooms, toilets and bedrooms. Staff described how they encouraged people to be as independent as they were able to be in daily living activities. People confirmed that they chose how they wanted to spend their time, when they wished to go to bed and staff responded when people asked for support such as to have bath or access food or drink.

Staff showed kindness and compassion when supporting people. We saw an example of staff using diversion and calming techniques to settle a person who was anxious, with positive outcomes for the person. A staff member approached the person and gently guided them into a room and started a conversation about their family which helped to settle the person. Staff were observed kneeling down or

pulling up a chair next to people so that they had eye contact when speaking with people sat in chairs. Staff spoke exclusively to people and avoided any interruptions from others.

Notice boards at the service were easily accessible and offered a variety of information to everyone living there or visiting. The notices and information displayed helped to keep everyone up to date with the management of the service and also included information on how to access local advocacy services. Where people did not have family members to support them to have a voice, the registered manager and staff had a good knowledge of how to access local advocacy services. An advocate acts as an independent person to help people express their needs and wishes, as well as assisting people to make decisions which are in their best interests.

An example of this was where staff had sought support from an Independent Mental Capacity Advocate (IMCA) with regards to supporting people to make informed decisions regarding their health.

People's personal information was handled confidentially. When staff were required to share information about people this was undertaken in a discreet and sensitive way so that conversations were not overheard by others. The registered provider had made confidentiality and data protection policies available to all staff. This meant that people's privacy was being protected by a registered provider who had suitable procedures and by staff who knew about these.

Is the service responsive?

Our findings

People confirmed that there were always activities taking place at the service. They told us, "There are plenty of activities going on. Yesterday there was a party for someone and at Christmas I have been asked to get involved with the service and celebrations which I am looking forward to".

Electronic care plans were in place and provided information in relation to the care people required to keep safe from harm. We noted that care plans we reviewed were task orientated in their focus and did not always clearly evidence how a person preferred their care to be provided. Comments such as 'provide assistance with eating and drinking as required' or 'with personal care' were recorded on care plans. There was varied information recorded to outline an individual's specific support needs in these areas. Daily records completed by staff over a 24 hour period also focused on where people had received personal care or support with their health or medical needs. Where people required support with moving and handling, there was an improved level of information in records as to how many staff were required to support people safely and what equipment was required to be used. However, care plans contained limited information regarding people's personal life history or when and how they preferred their care to be delivered. Discussions with staff provided good evidence that they had a good understanding of each person's preferences and the majority of people commented positively about the care they received. We spoke with the registered manager and provider regarding the development and personalisation of care plans records to ensure people's preferences were clearly recorded for staff less familiar with working at the service to follow.

Supplementary records used for recording food and fluids were not consistently completed, totalled or evaluated to effectively monitor people's intake. Where people had been identified as high risk weight loss we found large gaps in the information recorded. Care plans for one person stated 'supplementary drinks in situ due to weight loss' and 'monitor food and fluid intake'. We found that food and fluid intake for this person had not been completed or evaluated consistently. On the 3 November 2017 the only recorded entry for food and fluid intake was for 200mls of hot chocolate. There was no information recorded to evidence that supplementary drinks had been consumed. Records for another person who was also identified as a high risk of weight loss contained advice from a dietician that they required to be weighed on a weekly basis and food and fluid intake to be monitored. Supplementary records did not clearly identify the amount of food and fluid that the person required over a 24 hour period or what they had eaten or drunk. Comments such as 'hot chocolate' and 'sips' were regularly written to describe fluid intake. Care plans showed that the person had not been weighed weekly with gaps of up to three weeks between measurements being recorded. Even though we found no evidence of harm to people supported and observations showed that people received good levels of food and fluids during our visit, the lack of effective record keeping placed people at increased risk of dehydration and inadequate nutrition.

Each person living at the service had a completed Braden Assessment in place. This is an assessment used to assist staff in assessing a person's risk of developing a pressure ulcer. Care plans we reviewed for two people identified that they required regular repositioning to prevent deterioration in their skin integrity. Repositioning charts were located in their bedrooms and on review of the information recorded we found that these were not completed as required. Both people required repositioning every four hours. Records

spanning a nine day period between the 6 and 15 November 2017 showed a total of only 24 entries for one person where they had been repositioned. For the other person gaps of up to twelve hours were noted on repositioning charts. Again, through discussions with staff it was clear they understood the importance of maintaining people's skin integrity and had all participated the 'React to Red' training. React to red skin is a campaign across health and social care to recognise people at risk and prevent pressure ulcers developing. Whilst we found no evidence of harm had occurred to people supported the lack of effective record keeping placed people at increased risk of the development of pressure ulcers.

We raised this with the registered manager and provider who advised that they would address effective record keeping with all staff following our visit.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider failed to maintain accurate, complete and contemporaneous records in respect of each person supported.

There was an activities programme in place. An activities coordinator was employed to help meet people's social needs. Information relating to activities was available throughout the service for people to refer too. Activities such as arts and crafts, pet therapy sessions, games, raffles, music and entertainers were available. On the second day of our visit some people were celebrating the Queens 70th Wedding Anniversary and a range of items had been made available for them to use such as flags, hats and party items. When people came to live at the service, the activity coordinator spent time gaining information relating to peoples social hobbies and interests and considered how these could be included in the day to day activities. This showed that the registered provider understood the importance of promoting meaningful engagement for people living at the service.

People told us, "I'm very happy here and my son is happy that I'm looked after and I cannot fault the place. I've nothing to complain about and if I did I would just go and see the manager" and "If I did have anything to complain about I would just mention it to the staff. They would sort it out for me". The registered provider had a complaints policy and procedure in place. An easy read version of the complaints procedure was also available. The procedure gave details of who people could speak with if they had any concerns and what to do if they were unhappy with the registered provider response. People and their family members confirmed that if they had cause to make a formal complaint they would go the management team if they needed to. Records evidenced that were complaints had been received they had been dealt with appropriately within the registered providers own timescales.

The service had also received a number of compliments from people and their family members. Feedback shared included, "I would like to express my sincere thanks for the wonderful care you have provided to me", "Thank you for the attention given to my relative" and "We cannot thank you enough". We also saw records of compliments thanking staff for the tremendous work they had undertaken to support their relatives through difficult times in their lives.

Staff spoke to us about their experiences in supporting people with their end of life care needs. They told us "This is an important part of our roles here and we must get it right. We support the person and their loved ones through this difficult time and try to ensure people have a pain free and dignified death". The registered provider ensured that staff have access to the 'Six steps' end of life training which supports the wishes, preferences and choices of people at this stage of care.

One person told us, "The staff arranged for someone to come and talk to me about my last wishes. It's always a difficult realisation, but I felt relieved once I had plans in place for what I would like to happen. It

takes the pressure off my family". Some people had a 'do not attempt resuscitation' (DNACPR) order in place which had had been authorised by their GP. These are put in place where people have chosen not to be resuscitated in the event of their death or in cases where they cannot make this decision themselves, where the GP and other individuals with legal authority have made this decision in a person's best interests. Staff knew which people had a DNACPR in place therefore knew how to respond in the event of a person's death.

Is the service well-led?

Our findings

The service is currently managed by a person registered with the Care Quality Commission (CQC) since 2015. We received mixed feedback in relation to the management of the service. Comments included, "I know the manager, and they come around to check that we are ok", "Yes I know who the manager is, you see her floating about the place quite often" and "Sometimes they complain about things like paperwork and rotas and I don't think that's for me to know". The registered manager left part way through the first day of our inspection and was unavailable to attend the second day of our visit.

The registered provider had a system of quality management in place which was designed to identify areas of improvement in the service. The audit system included a review of different aspects of the service, such as care plans, supervisions, medicines, health and safety, environmental cleanliness, and the control and prevention of infections.

There was a lack of clarity in relation to how often audits were to be completed at the service. Senior team members advised on approximate timescales for the completion of audits. An example of this was the completion of the quarterly infection control audits. The last audit completed prior to our inspection visit was in June 2017. This meant that this specific audit was overdue. Monthly audits were in place to ensure that bedrooms were deep cleaned on a regular basis and monitored. However, the last audit record shared with us was dated October 2016. Through discussions it was clear that the oversight and management of the audits was the sole responsibility of the registered manager. Staff were not always aware of where completed records were stored or held at the service to enable them to access or implement audits in the absence of the registered manager. There was a lack of management oversight to ensure that checks were carried out as required across the different areas of the service. Accessibility to records and shared responsibility was discussed with both the registered manager and provider following our visit.

The registered provider's medication audit was not robust. Checks included medicines fridge temperatures, the condition and cleanliness of the clinical room, errors relating to medication administration, medication stock checks and checks on the accurate completion of medication administration charts (MAR). However, there was limited evidence recorded to highlight what actions had been taken to address areas of improvement. Records dated February, May, June, July and September 2017 contained comments relating to 'drug errors' that had occurred at the service. Audits contained no specific details with regards to what errors had occurred other than 'reported as low level safeguarding' recorded next to them. There was no information in relation to whom the errors had occurred with and what actions had been taken by the registered manager and staff to learn from these incidents and prevent the risk of further errors occurring. This meant that the registered manager and provider were not effectively monitoring or identifying risks and trends to ensure the management of medicines remained safe and effective. We raised this with the registered manager who confirmed that all errors were discussed with her; however these discussions and any actions taken had not always been recorded. The registered provider stated they would review the medication audit following our visit to ensure that it was fit for purpose.

Audit processes had not identified or been utilised to address the lack of appropriate recording and

monitoring in relation to supplementary records. As highlighted in our responsive domain, care plans required personalisation and information written focused heavily on medical and health needs of people supported. It is essential to have a robust system of audit in place in order to identify concerns and make necessary improvements to ensure people are provided with a safe and effective service. Areas of improvement we identified during our inspection visit had not been identified as part of the quality monitoring system within the service nor as part of the registered manager's ongoing monitoring of the care provided at the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider did not have effective systems and processes in place to monitor and improve the quality and safety of the service.

Accidents and incidents were monitored through the registered provider's quality assurance processes. Where accidents or incidents had occurred these had been appropriately documented and investigated. Records included a description of what had happened, when and who was involved. Where these investigations had found that changes were necessary in order to protect people, these issues had been addressed and resolved promptly. This meant the registered provider was monitoring incidents to identify risks and trends and to help ensure the care provided was safe and effective.

People told us, "There is a residents meeting once a month in the lounge and it's usually well attended and we talk about all sorts of things. I always feel listened too and a part of discussions" and "The meetings are really informative as we can give feedback on what we don't particularly like. They always do their best to listen and make any changes as needed". The registered provider's philosophy of care included ensuring that people understood that the service was their 'home' and that they would be listened too. The registered provider had systems in place to seek the views of a wide range of stakeholders about their experience and views of the service. Alongside residents meetings, people and their family member had taken part in 'satisfaction surveys', focusing on five key areas about the quality of the service. These included, 'everyday experience', 'care and service', 'staff', 'food and beverage' and 'grounds maintenance and other services'. The results of the surveys were analysed by the registered provider to see if any actions or improvements were needed. Comments such as, "Warm and friendly service", "good communication with relatives" and "good attention to special events and activities" were recorded. The registered manager and provider confirmed that the service always operated an open door policy and they were always available for people to speak with. This demonstrated that the registered provider valued people's opinions and feedback.

Staff members told us, "Staff meetings are becoming more frequent now. They are very helpful and we do have improved streams of communication". Staff were supported to attend team meetings to access up to date information regarding any changes at the service. Staff members commented that there had been a lot of changes at the service over the last 12 months but that things were starting to get 'back to normal'. Minutes we received evidenced that team meetings had started to re-commence and staff felt more supported in their role.

The registered provider had a comprehensive set of policies and procedures for the service, which were made available to staff along with other relevant up to date information and guidance. This information assisted staff to follow legislation and best practice when providing support and care to people.

The registered manager had an awareness of her responsibility in line with the Health and Social care Act 2008. Registered providers are required to inform the Care Quality Commission (CQC) of important events that happened within the service. The registered manager was aware that CQC are required to be informed of specific events by law to ensure people are kept safe and well. CQC had been appropriately notified of any

significant incidents that had occurred at the service since our last inspection.

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
Treatment of disease, disorder or injury	The safety and security of the building was not always managed appropriately. People's safety was not adequately protected and appropriate actions were not taken to mitigate risks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider failed to maintain accurate, complete and contemporaneous records in respect of each person supported. There was a lack of effective systems and processes in place to monitor and improve the quality and safety of the service.