

# Four Seasons Homes No.4 Limited

## Marquis Court (Tudor House) Care Home

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Inadequate ●

# Summary of findings

## Overall summary

We carried out an unannounced inspection at Marquis Court Tudor House on 20 March 2018.

Marquis Court Tudor House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 52 people in one adapted building, arranged over two floors. At the time of our inspection, there were 30 people living there, some of whom were living with dementia. There is a communal lounge and separate dining room on each floor and a small garden area to the front and side of the home.

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

The service has been rated as 'requires improvement' at the four comprehensive inspections carried out since 2014 and there have been repeated breaches of the regulations. Our last comprehensive inspection of this service was on 22 February 2017. We found the provider was not meeting the regulatory requirements because people were not always protected from the risks associated with their care, there were insufficient staff to support people in a timely way and people were not always treated with dignity and respect. The provider's quality assurance systems were not effective in identifying shortfalls and ensuring that regulatory requirements were met. We rated the service as 'requires improvement'. Following the comprehensive inspection, we issued a warning notice and told the provider to take action to ensure people received safe care and treatment by 24 April 2017. The provider sent us an action plan saying how and by when they would meet the legal requirements. On 15 May 2017, we undertook an unannounced, focused inspection to check that they had followed their plan and taken the relevant action needed to meet the requirements of the warning notice. We found that the required improvements had been made to the way risks were managed and that people were protected from avoidable harm. This meant the warning notice had been met.

At this comprehensive inspection, we checked that the provider had met the remaining legal requirements and had improved the key questions of safe, effective and well-led to at least 'good'. We found some improvements in the management and oversight of people's care and we saw significant improvements in the staff culture, reflected in people's views that staff were consistently kind and caring. However, further improvements were needed to ensure people received timely, personalised care and that systems to monitor the quality and safety of the service were effective in ensuring the service is consistently well led and meeting all legal requirements.

We found there were not enough staff to support people in a timely, person centred way that promoted their dignity at all times. Systems used to set staffing levels were not effective in ensuring there were sufficient staff available to meet people's individual needs and preferences at all times. People were protected from the risk of abuse and staff knew what actions they should take to minimise the risks associated with people's care. However, we could not be assured there were sufficient staff to support people to stay safe at all times.

People did not always feel involved in planning their care and people's individual needs were not always identified and met. People were not always supported to access activities that interested them and were relevant to their needs and preferences. We have recommended that the provider seeks guidance in this area to ensure people are supported to have choice and control over how they receive their care. People and relatives were asked for their feedback on the service but we could not be assured that the systems used were always effective in identifying concerns and areas for improvement.

Most people enjoyed a positive mealtime experience but the availability of staff meant people were not always supported to manage their dietary needs. People received their medicines when needed and there were suitable arrangements in place in relation to the safe administration, recording, storage and disposal of medicines.

The provider followed safe recruitment procedures to ensure they were safe to work with people. Staff received training and ongoing support to fulfil their role. The provider monitored this to ensure they provided care in line with best practice.

The provider followed legal requirements when people lacked the capacity to make certain decisions. People were supported to have maximum choice and control of their lives and staff did supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported by staff who were kind and caring and encouraged them to have choice over their daily routine. People had access to their GP and other health care professionals when needed. People were encouraged to maintain relationships with family and friends and visitors were not restricted.

There was an open, inclusive atmosphere at the service. People and their relatives felt able to raise any concerns and complaints with the registered manager and staff. Staff felt supported by senior staff and the registered manager.

The registered manager had notified us of important events that occurred in the service, as required by their registration with us.

We found continued breaches of the regulations. We have asked the provider to send us a written report setting out how they plan to improve the quality and safety of the service and the experience of people using the service. They must send this to us by no later than 28 days after receipt of our request. We will continue to monitor the service and may take enforcement action if we are not satisfied with their progress.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

We could not be assured there were always sufficient staff to provide timely care that ensured people were protected from avoidable harm at all times. People were protected from the risk of abuse and the provider followed recruitment procedures to ensure staff were suitable to work with people. People received their medicines when needed. Systems were in place to ensure adverse incidents were investigated and lessons learnt to prevent reoccurrence.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective

Improvements had been made and most people enjoyed a positive mealtime experience. However, people were not always supported to manage their dietary needs. People's rights were upheld in line with the Mental Capacity Act 2005 when they lacked the capacity to make certain decisions. Staff received training and support to fulfil their role. People were supported to manage their day to day health needs. The home environment was accessible for people.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring.

Staff did not always have the time to support people in a person-centred way which ensured their dignity was maintained at all times. However, staff were kind and caring and had good relationships with people. People were able to make choices over their daily routine and staff encouraged them to maintain their independence. People were encouraged to maintain relationships with family and friends and visitors were not restricted.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive.

**Requires Improvement** ●

The availability of staff sometimes meant people were at risk of not receiving their planned care. People did not always feel involved in planning their care and people's individual needs and preferences were not always identified and met. People were not always supported to follow their interests and take part in activities that interested them and met their needs. People and their relatives felt able to raise any concerns and complaints with the registered manager and staff.

**Is the service well-led?**

The service was not always well led.

The provider's quality assurance and governance systems needed to be improved to ensure the service was consistently well led and meeting all legal requirements. Systems used to set staffing levels did not always take into account factors that impacted on the time staff needed to support people safely, and in a person-centred way. We could not be assured that the provider's systems for gathering people's feedback were always effective in identifying concerns and areas for improvement. There was a positive, inclusive culture at the service and staff felt supported by senior staff and the registered manager. The registered manager was meeting the requirements of registration with us.

**Inadequate** 

# Marquis Court (Tudor House) Care 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 20 March 2018 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. 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 used information we held about the service and the provider to assist us to plan the inspection. This included statutory notifications informing us of important events in the service, which the provider is required to send to us by law. The provider also sent us a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We had also received information from local authority commissioners and the safeguarding team who had been monitoring the service since February 2017 due to concerns about the care people were receiving. This included confirmation that the embargo placed on new admissions to the service had been lifted in January 2018. We used all this information to develop our inspection plan.

We spoke with nine people who used the service and two relatives, five care staff, a nurse, the registered manager and two members of the provider's senior management team. We also spoke with two visiting health professionals. We did this to gain views about the care and to ensure that the required standards were being met.

We looked at the care records for eight people to see if they accurately reflected the way people were cared

for. We also looked at staff duty rosters, three staff files and information relating to the management of the service.

# Is the service safe?

## Our findings

At our last comprehensive inspection, we found that there were insufficient staff to meet people's needs at all times. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) regulations 2014. The provider has been in breach of this regulation at our inspections in December 2014 and November 2015. In September 2016, staffing levels were increased and the breach was met but these improvements were not sustained and we found the breach had reoccurred at our inspection in February 2017. At this inspection, we found that staffing arrangements continued to be ineffective and people's needs were not being consistently met.

People had mixed views when we asked if there were enough staff available to support them. One person told us the staff came quickly when they pressed their buzzer and relatives we spoke with had no concerns about the availability of staff. However, some people thought there were insufficient staff to meet their needs and told us they had to wait for staff to become available to support them. One person said, "There are not enough staff. There are only two carers on and so many people need two staff to support them, at least one more member of staff is needed". On the morning of our inspection, two people told us they had been up since 7:30 am and were waiting for staff to support them with their breakfast at 9 am. One person said, "I haven't had my breakfast yet, I wait and see when it comes. I've had a drink but I could do with another now". Later in the morning, we saw that staff were still supporting people to get up at 11 am on the nursing unit. Fourteen of the 15 people on the unit required the support of two staff to support them safely. This left just one member of staff available which meant people would have to wait until another member of staff became available when they required support. At times we saw there were no staff available in the communal areas because staff were supporting people in their bedrooms. For example, during the morning the communal lounge on the nursing unit was unsupervised for 30 minutes and we heard a person calling out for assistance for ten minutes until a member of staff returned to the lounge to assist them. Staff told us the communal lounge and dining room was not to be left unsupervised because people were at risk of falls or needed to be encouraged with meals and drinks to minimise the risk of choking. This showed us staffing levels had an impact on the timeliness of people's care and placed people at risk of not receiving care in line with their assessed needs.

The registered manager explained how staffing levels were calculated using a dependency tool and showed us that the required staffing numbers were being met. On checking the staff rosters we found that on a number of occasions, they did not always reflect the dependency tool. For example, on four occasions in February and March 2018, staffing levels were reduced from three to two care staff on the nursing unit and on two other occasions, cover had only been provided for part of the shift. This meant that the provider had not ensured people were always supported by sufficient staff.

We found that the dependency tool was not consistently completed. The information detailed in people's care plans did not always match that shown on the dependency tool. For example, we found that two people's profiles did not match the dependency tool and another person's profile had not been completed in their care plan so we were unable to establish if it was correct on the dependency tool. In addition, the



occupancy at the home had increased from 24 to 30 people since February 2018 which meant staff were still getting to know people and would have an impact on the time staff needed to support people in a person-centred way. There was no evidence that this had been reflected in the dependency tool calculations.

Following our inspection, the provider contacted us to advise that they had reviewed the dependency levels and corrected the anomalies we identified. They told us this showed that they continued to meet the required staffing levels. They also advised that they were reviewing staff deployment within the home and were confident that this would impact positively on people's care.

However, in view of the provider's history of staffing concerns, we could not assure ourselves that staffing levels were effectively assessed and monitored to ensure they were sufficient to meet people's needs at all times.

This is a continued breach of Regulation 18(1) of the Health and Social Care Act (Regulated Activities) regulations 2014.

Staff told us and records confirmed that the provider carried out checks to ensure staff were suitable to work with people. These included checks of references and the Disclosure and Barring Service, a national agency that keeps records of criminal convictions. In addition, the registered manager had checks in place to ensure that nurses were registered with the Nursing and Midwifery Council. This showed us the provider followed procedures to ensure staff were suitable to carry out their role.

At our last comprehensive inspection, we found concerns that risks associated with people's care were not always safely managed. We issued a warning notice and told the provider to make improvements by the end of April 2017. We carried out a focused inspection in May 2017 and found that the required improvements had been made. At this inspection, we found that the improvements had been sustained. People told us they felt safe and well cared for by the staff. One person told us, "I feel safe here, the girls are marvellous". Relatives we spoke with told us they had no concerns about their family members. One said, "It's the first time we have visited and [Name of person] looks really well". Risks associated with people's care were assessed and managed. Staff understood the risks to people's safety and wellbeing and how to manage them. . However, the lack of available staff meant that people were placed at risk of not receiving the support they needed to stay safe at all times.

Staff were aware of the signs to look for that might mean a person was at risk of abuse and knew what to do to make sure that any concerns were investigated and people were protected. One member of staff told us, "I would report any concerns and know how to go to safeguarding directly if I need to. It's taken very seriously here". There were effective safeguarding systems in place which followed local safeguarding procedures. We saw that where required, concerns had been reported to the local safeguarding team and investigated thoroughly. The registered manager notified us of any safeguarding concerns in accordance with the requirements of registration with us.

People told us they received their medicines when they needed them. One person said, "I get my tablets on time and I can get extra pain killers if I need them". We observed staff administering medicines and saw that they spent time with people and ensured they had taken their medicines before leaving them. Systems were in place to ensure medicines were administered, recorded, stored and disposed of in line with legal requirements. Some people received their medicines covertly, which means they are given without their knowledge. We saw that this was carried out in accordance with legal requirements and best practice. Staff received training to administer medicines and they were observed periodically by the registered manager to ensure they remained competent.

People were protected by the prevention and control of infection. We saw that the home was clean and personal protective equipment was available for staff and people who live at the home to use when needed. We saw the staff had received training and followed clear policies and procedures to maintain good standards of cleanliness and hygiene in the home.

The provider had systems in place to review when things go wrong to ensure that lessons were learnt and that action was taken to minimise the re-occurrence. Accidents and incidents were thoroughly investigated, for example, we saw that action had been taken to address medicines errors.

## Is the service effective?

### Our findings

At our last comprehensive inspection, we found the provider had not achieved the improvements they told us they would make and concerns remained that people did not always have a positive mealtime experience. At this inspection, we found some improvements with people's mealtime experience but further improvements were needed to ensure people were always supported to manage their dietary needs. One person had been referred to the dietician because they were losing weight. At lunchtime, we saw they were no staff available to encourage them to eat their meal and they ate only a few spoons before falling asleep. A member of staff cleared their meal tray after 35 minutes and brought them some fresh fruit but they did not stay with them to encourage them to eat. This meant the risk of further weight loss was not being minimised whilst advice was obtained from the dietician. Another person had been referred to the dietician in February 2018 but the person's care plan did not show that a visit had taken place or further advice received. Staff told us the person had been discharged by the dietician as there were no changes needed to the person's care. However, they were unable to show us this information and we saw that the person had continued to lose weight. The registered manager followed this up after the inspection and contacted us to confirm that they were to continue with the advice already received. However, the gaps and inconsistencies in the records meant that these people were at risk of receiving care that did not meet their ongoing needs.

People told us they enjoyed the food. One person said, "The food is excellent and there's plenty of it". We saw people were offered a choice of food and drinks and people's individual preferences were catered for. One person said, "If you don't like something on the menu they'll find you something else". We saw the chef was knowledgeable about people's individual needs and preferences. For example, they explained how soft diets were provided for people who were at risk of choking. We saw this information was visible in the kitchen and kept up to date when people's needs changed. Although we have identified some areas for improvement, we saw that people's weight was monitored and they were referred to the dietician and speech and language therapist when needed.

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 or 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider was following the MCA. We saw that people's mental capacity had been assessed to reflect their ability to make decisions for themselves and where decisions were being made in people's best interests, these were documented. For example, best interest decisions were in place for administering people's medicines. Staff we spoke with told us they had received training in the MCA and Deprivation of Liberty Safeguards (DoLS) and demonstrated an understanding of the legislation. One member of staff told us, "If people don't have capacity to give their consent we have to look at how to make

the decision in their best interest, for example for their medicines". Staff recognised their responsibilities to support people to make decisions where they were able. One member of staff told us how they supported a person to make decisions about what they wore each day; "We get things out of the wardrobe and hold them up for them to choose". We observed staff asking people for their consent before they provided care, for example when supporting people to move using equipment. This showed us staff understood the importance of gaining verbal consent.

We saw that the registered manager made applications for people who were being restricted of their liberty in their best interests and notified us when approvals were received, as required by their registration with us. This showed the registered manager and staff were working within the principles of the legislation.

Staff told us they received an induction and ongoing training to fulfil their role. We saw that staff completed a range of training relevant to the needs of people living at the home. The registered manager and staff were supported by the provider's resident experience team, who attended the home on a regular basis to provide in-house training and ensure staff delivered care in line with best practice. Staff told us they received regular supervision and an annual appraisal which gave them the opportunity to raise any concerns, discuss their performance and agree any training needs. These arrangements ensured staff had the skills and knowledge they needed to support people effectively. This meant the provider had addressed the concerns we identified at the last inspection.

People were supported to access other health professionals such as the GP, district nurse and optician. One person told us, "I've seen the GP recently and I'm taking some antibiotics at the moment". Two visiting professionals we spoke with told us the staff contacted them promptly when they had concerns and acted on any advice given. This showed us people were supported to maintain their day to day health needs.

The home environment was accessible to people and promoted their independence. Some people were able to access the grounds independently. One person told us they had a greenhouse where they could grow salad and vegetables. People decorated their rooms to their individual preferences.

## Is the service caring?

### Our findings

At the last inspection, we found people were not always treated with respect and people's dignity was not promoted at all times. This was a continued breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) regulations 2014. At this inspection, people told us the staff were kind and caring and treated them with respect. One person said, "The staff are very good and kind". A relative told us the staff were caring and had helped their family member to settle in quickly. They told us, "The staff are very good, [Name of person] has settled much better than I thought they would". However, staff told us they did not always have enough time to support people in the most person-centred way. One member of staff told us, "It's like the residents are on a conveyor. The staff get upset at not having the time to support people properly". All the staff we spoke with told us there were insufficient staff available to ensure people's needs were met at all times. On the nursing unit, staff told us they sometimes supported people alone when there should be two members of staff. One member of staff said, "There are not enough of us. There should be three care staff but a lot phone in sick so we drop down to two and it's hard to cover the shift. Everybody should be doubling up to support people but we don't have the staff to do it. We do most of what we can alone and then hoist together; it's too much". This showed us that people did not always receive timely support in the most dignified way. Staff told us they had raised their concerns with the registered manager and provider. One member of staff said, "The management know, we tell them. They say we have enough staff for the ratio of people, they don't consider people's needs or how much support they need".

Although the staff were busy, we did see examples of positive interactions with people. Staff covered people with blankets when supporting them to move using equipment and prompted people discreetly if they needed to re-arrange their clothing after using the bathroom. Staff supported people to maintain their appearance by offering them aprons when they were eating and helped them to wipe their hands and faces after their meal. People were able to get their hair done each week. One person told us, "I've always had my hair every week; it's how I like it". We saw that people's privacy was respected because staff knocked on people's doors and waited to be asked in. Staff spoke discreetly with people when assisting them to go the bathroom and took them to their rooms to support them with personal care. Although staff were busy, we saw they responded when people became anxious and spent time reassuring and checked they were settled. For example, we saw that staff spent time reassuring a person who had only recently moved to the home. This showed us staff cared about people's wellbeing.

People were offered choice about their daily routine, for example what they wanted to eat and who they sat with. We observed staff offering to cut people's food up but waited until they confirmed it was what they wanted. Staff respected people's wishes when they wanted to remain in their rooms. One person told us, "I'm staying in bed today; I'll get up tomorrow". Staff encouraged people to be as independent as possible. One person told us they were able to make a hot drink for themselves and there was a vending machine in the dining room people were able to use. Staff were patient with people and encouraged them to walk with support or to eat their meal independently where appropriate.

People were supported to maintain important relationships. People told us their friends and relatives were

able to visit without restriction. One person said, "It's open visiting and my family visit me often". A relative told us, "We come and go as we like. [Name of person] is having their hair done at the moment so we'll come back later".

## Is the service responsive?

### Our findings

At the last inspection, there was no activities co-ordinator in post and staff did not have the time to support people cared for in their bedrooms to join in activities and avoid social isolation. At this inspection, there was an activity co-ordinator at the service but we found the same concerns. People told us they did not see the activities co-ordinator and the only interaction they had with staff was in relation to care tasks. One person said, "I was led to believe I would mix and socialise with people here but it doesn't happen. I've been here for three months but I've only been downstairs for one meal and to one coffee morning". Another person said, "The activity worker doesn't come to my room. I get put in this chair in a morning and I stay here all day long until I'm put back to bed". Staff told us they were expected to support people with activities but this was not possible due to staffing levels. One member of staff said, "We don't really have time for activities with people so we usually put a film on". We saw that staff put on DVD's but most people were asleep and there was no consideration as to whether they met people's preferences. For example, one was Mary Poppins and the other the BFG. Staff told us the activities co-ordinator usually spent most of their time on the residential unit and people occasionally went downstairs to join in with activities. We saw there was a programme of activities for the day which included watching the Commonwealth Games opening ceremony, the hairdresser and a musical afternoon. Whilst we saw people on the residential unit enjoyed watching this and people had their hair done, no activities took place in the afternoon. The activities co-ordinator told us they were not always able to offer activities on both units and support was usually needed from members of the care staff. This meant people supported in their bedrooms remained at risk of social isolation and meant the provider had failed to act on concerns raised at the last inspection.

People did not always receive care and support that met their individual needs. One person received their medicines and nutrition through a percutaneous endoscopic gastrostomy (PEG), a flexible feeding tube placed through the abdominal wall and into the stomach. We saw that the person's lips were dry and we spoke with a member of staff who told us they applied cream to maintain the person's comfort. However, on checking we found there was no record of the cream being applied and no care plan in place to ensure staff had the information they needed to provide care that met the person's individual needs. The nurse told us they would put one in place immediately.

We found that care records were not always accurately completed. Staff were supporting a person who had skin damage and their dressings needed to be reviewed every three days. The person's wounds were healing and staff were confident that the required checks had been carried out. However, the person's care records did not demonstrate that this had always happened. However, gaps and inconsistencies in the records meant that this person was at risk of receiving care that did not meet their ongoing needs.

People were not always provided with information to help them to be involved in decisions about their care. Two people we spoke with were not sure what was happening in relation to them being discharged from the home. One person said, "I've had no say in anything since I came here from hospital. My family find it difficult to visit as we don't live in this area. I believe I'm here for reassessment but I've no idea how long I'll be here". Some people told us they had not been asked about their wishes in relation to their religious

beliefs. One person told us, "I'm not aware of any religious services; my husband was a clergyman and I would like to take communion if offered". The registered manager told us that services were held at the home by two local churches each month. However, it was not clear if people who were cared for in the bedrooms were supported to access this. This meant the provider had not ensured that people's diverse needs were recognised and met.

We found that people were not always asked for their preferences for who provided their care. One person said, "The male staff are very good but I wasn't given a choice or asked if I minded". Another said, "There are male staff, I've not been given a choice but they are good and kind and they usually work with a female carer". This showed us people were not always given choice and control over their care.

We recommend the provider seek advice and guidance from a reputable source to ensure people are supported to express their views on how they wish to receive their care and support.

People and their relatives told us they would speak to a member of staff or the registered manager if they had any concerns or complaints. One person said, "I know the manager, she's very approachable. If I have any complaints I tell her. I have in the past and it has been sorted out". The complaints procedure was published on the notice board in the reception area and there was a system to log any concerns or complaints. We saw that the registered manager recorded and responded to complaints in accordance with the provider's policy and procedures.

At the time of the inspection, the provider was not supporting anybody with end of life care. However, discussions showed that systems were in place to ensure people were supported at the end of their life to have a comfortable, dignified and pain-free death. People's wishes were identified and the provider worked closely with healthcare professionals to ensure that people's changing needs could be met.



# Is the service well-led?

## Our findings

We have carried out four comprehensive inspections at this service. On all four occasions, the service has been rated as 'requires improvement', with a repeated cycle of breaches and any improvements not always being sustained. At our last comprehensive inspection, improvements in staffing levels had not been sustained and there was a lack of consistency in the management of the service and the provider's quality assurance systems were not always effective in ensuring legal requirements were met. We found continued breaches of the Health and Social Care Act (Regulated Activities) regulations 2014 in Regulations 17 and 10 and the failure to sustain improvements in staffing meant a breach of Regulation 18 (1) had reoccurred. The service has not met some of the regulations since December 2014. We have taken this into account when considering our rating in this domain.

At this inspection, we found some improvements in the management and oversight of people's care and we saw significant improvements in the staff culture, reflected in people's views that staff were consistently kind, caring and compassionate. However, continued breaches of the regulations demonstrate that the service is still not consistently well led and does not give us confidence that the provider can deliver and sustain the improvements needed to ensure the health, safety and welfare of people using the service.

We found continued concerns about the staffing levels at the home and people's individual needs and preferences were not always met in a timely way. The provider was confident that their dependency tool was effective in setting safe staffing levels. However, people told us and we saw that they did not always experience positive outcomes. Following our inspection, the provider contacted us to advise that they had reviewed the dependency levels and corrected the anomalies we identified. They told us this showed that they continued to meet the required staffing levels. They also advised that they were reviewing staff deployment within the home and were confident that this would impact positively on people's care. However, in view of the provider's history of staffing breaches, we could not assure ourselves that staffing levels were effectively assessed and monitored to ensure they were sufficient to meet people's needs at all times.

The registered manager carried out a range of audits including checks of medicines administration, care plans, accidents and incidents and infection control. However, we found these were not always effective as they had not identified the concerns we found with the accuracy of wound records and the monitoring of advice received to manage people's weight loss. Furthermore, daily checks to ensure the safety and wellbeing of people cared for in their rooms were either not carried out or were ineffective. We found that people's call bells were not always in reach. One person told us they hadn't got their buzzer and we found that the lead was not attached. Staff eventually located it in a chest of drawers but the person would not have known where it was and couldn't reach it. In other people's rooms we saw that drinks were provided but they were not placed within people's reach. This meant people were at risk of not receiving responsive care when they needed it.

The provider had systems to gather people's views on how the service could be improved through the

completion of surveys and resident's meetings. However, some people were not aware of how they could give their feedback and others did not feel their views were listened to. One person said, "There was a resident's meeting yesterday but I didn't go, I used to but I feel it's a waste of time as nothing changes". This showed us people did not always feel involved in decisions regarding the running of the home.

We saw the results of the latest survey for the period November 2017 to February 2018 were published in a 'you said, we did format' at the entrance to the home. This showed that people felt they were not always given the help they needed to eat and drink. There was no supporting information on what action the provider had taken to address these concerns. The provider told us they believed there were issues with the way the question had been written which meant that people had given incorrect responses. However, they could not provide any evidence to show that they had carried out any further investigation or monitoring of mealtimes to validate the results. In addition, this feedback did not reflect the views that people had shared with us about staffing levels and their dissatisfaction with the availability of social activities. This meant we could not be sure that the provider's systems for gathering and acting on feedback were always effective at identifying concerns at the home.

These concerns demonstrate a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) regulations 2014. Under Regulation 17(3), we have asked the provider to send us a written report setting out how they plan to improve the quality and safety of the service and the experience of people using the service. They must send this to us by no later than 28 days after receipt of our request. We will continue to monitor the service and may take enforcement action if we are not satisfied with their progress.

There was a registered manager at the service. People told us the registered manager was approachable and were positive about the way the service was managed. One person said, "I've seen many improvements with this current manager; if I had any concerns I would tell them". There was a clear management structure at the service and staff understood their role and responsibilities. The atmosphere at the home was more open and inclusive than that found at our last inspection and staff told us they had worked together to bring about improvements at the service. Staff told us they felt supported by their team leaders and the registered manager and felt able to air their views in staff meetings. One member of staff said, "[Name of manager] is the best manager we've ever had. She encourages everyone to do the best they can and listens and supports us". We found the registered manager worked closely with commissioners and relevant agencies to ensure people received effective, joined up care.

The registered manager understood the requirements of registration with us. They reported significant events to us, such as safety incidents, in accordance with the requirements of registration. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and on their web site where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good Governance.  People were not protected from risks associated with ineffective monitoring and evaluation of the service. Regulation 17(1) & (2) (a) (b) (e) & (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing.  People were not protected from the risk of receiving unsafe care because the provider did not consistently ensure sufficient staffing levels. Regulation 18(1)