Four Seasons 2000 Limited

Bishopsmead Lodge

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Bishopsmead Lodge is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bishopsmead Lodge provides accommodation with nursing and personal care for up to 51 people. At the time of our inspection 43 people were living in the home.

At the last inspection on 15 March 2017 the service was rated Requires Improvement. We found a breach in the regulation relating to personalised care. Following this inspection, the provider sent us an action plan telling us how they would make the required improvements.

We carried out a comprehensive inspection on 17 and 18 April 2018. At this inspection, we found improvements had been made in the recording of personalised care and the legal requirement was met. However we found three breaches in the regulations relating to the management of medicines, meeting nutritional and hydration needs and quality assurance systems.

The service remains Requires Improvement.

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

Medicines were not always safely managed. The provider's monitoring and checking systems had not picked up when medicines had not been given as prescribed. This meant people were at risk of not receiving the care and treatment they needed.

There were on-going organisational safeguarding investigations at the time of our inspection, due to a number of care concerns raised. The provider had been required by the local authority safeguarding team to complete a protection plan to demonstrate that people were safe in the home.

Risk assessments and risk management plans were completed. Incidents and accidents were recorded and the records showed that required actions were taken to minimise future occurrences.

Sufficient numbers of staff were deployed at the time of our visit. There were significant registered nurse vacancies and the home was reliant on agency registered nurses on a regular basis each week to provide clinical expertise and leadership. Staff performance was not effectively monitored. Improvements were needed to make sure staff received supervision in line with the provider's policy, and to make sure they could meet people's needs.

Appropriate health and safety checks were undertaken to reduce risks to people. The home was clean and on most occasions staff followed the homes infection control policy and procedures.

People were not always provided with the support they needed with food and fluids and records were not accurately maintained. People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

People's legal rights were respected. People were supported to exercise control, consent to care and make decisions. The principles of the Mental Capacity Act (MCA) 2005 had been followed.

Staff were kind and caring. We found people were being treated with dignity and respect and people's privacy was maintained.

People who used the service felt able to make requests and express their opinions and views. People were helped to exercise choice and control.

The service that was not consistently well-led. Systems were in place for monitoring quality and safety. However, shortfalls in care were not always identified.

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 remains Requires Improvement.

Peoples medicines were not always managed safely and shortfalls were not identified. This meant people may not have received the medicines they had been prescribed.

Staff had received training and knew how to identify and act on safeguarding concerns.

Staff were safely recruited. Improvements were needed to make sure staffing levels and skill mix were sufficient to consistently meet the needs of people living in the home.

Accidents and incidents were reported and actions taken to reduce recurrences. Risk assessments were completed and risk management plans were in place.

The home was clean, safely maintained and health and safety checks were completed.

Is the service effective?

Requires Improvement

The service remains Requires Improvement.

The service complied with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).People were asked for consent before care was provided.

People were not always supported with food and fluids. Where records were required to monitor people's food and fluid intake, they were not accurately maintained.

Staff did not receive regular supervisions to help enable them to meet people's needs.

People had access to a GP and other health care professionals.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Requires Improvement

The service remains Requires Improvement.

Further improvements were needed to make sure the records accurately reflected people's needs.

A range of activities were provided to people, mainly in the communal areas of the home.

A complaints procedure was in place and this was accessible to people and their relatives.

Is the service well-led?

Requires Improvement

The service remains Requires Improvement.

Systems were in place to assess, monitor and mitigate risks and make improvements to the quality of the service offered to people. A range of audits were completed on a regular basis. However, these did not always identify shortfalls, for example in medicines management, meeting nutritional and hydration needs and staff supervision. Actions were not always taken when shortfalls were identified.

A registered manager was in post. People who used the service were given opportunities to provide feedback.

Staff were able to express their views and opinions at staff meetings and through surveys.

The registered manager recognised their responsibilities with regard to notifications they were legally required to send to the Commission.

Bishopsmead Lodge

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.

We undertook a comprehensive inspection of Bishopsmead Lodge on 17 and 18 April 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by 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.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law. Before the inspection, we had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make.

During our visit we spoke with 15 people who lived at the home and 5 visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the current area manager and a recently appointed area manager who was on their induction programme. We spoke with the registered manager, clinical lead nurse and 11 staff including a registered nurse, care staff, maintenance, housekeeping, laundry, activity and catering staff. We spoke with two visiting health professionals. We observed medicines being given to people. We checked how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at seven people's care records in detail and checked other care records for specific information. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, complaints records and other

records relating to the monitoring and management of the care home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in March 2017 we rated this key question as Requires Improvement. This was because risks were not always managed in accordance with people's needs. At this inspection we found improvements had been made. However, we found people's medicines were not safely managed. This key question remains as Requires Improvement.

We found gaps in the Medicine Administration Record sheets (MARs) from February 2018 leading up to the dates of our visit. There were 11 gaps where staff had not signed to confirm they had given the prescribed medicines to people. One of the gaps was for a dose of insulin for a person with diabetes. There was nothing recorded to show that staff had noted the gap or checked whether people had actually received their medicines. We brought this to the attention of the clinical lead nurse at the time.

For one person, pain relief had not been properly assessed and managed. A care plan entry on 18 February 2018 stated that the person's dose of a pain relieving patch had not been given to them on 15 February 2018. There was nothing recorded to show what action staff had taken. There were no records to state if this omission had an adverse effect or if the person had suffered increased pain as a result. The log book for medicines that require additional security showed that staff had administered the pain relieving patch 48 hours after it was due. This had not been reported as a medication incident. Therefore, no actions had been taken to prevent this happening again. This was not in accordance with the provider's policy that stated the actions expected when such an incident occurred. We brought this to the attention of the registered manager at the time.

Details of people's prescribed medicines were not always safely recorded. Medicine details were printed onto the MARs by the supplying pharmacist. Occasionally, registered nurses made hand written entries of the prescribed medicines. There was clear guidance in the provider's policy that described the circumstances in which this practice may be needed. For example, two members of staff were to check and sign the prescribers instructions had been correctly hand written onto the MARs. We saw this policy was not always being followed and handwritten entries were made by one registered nurse. On one occasion this was for a medicine that required additional security.

Some people had been prescribed topical creams and lotions. Instructions for staff on where and when to apply these were clear and included body maps. However, topical application charts had not been consistently signed by staff. For example, one person had been prescribed a barrier cream to prevent skin soreness. The instructions for staff were "apply to sore bottom several times a day." However, the chart had not been signed at all during April 2018. Another person had been prescribed a cream to moisturise their skin. The instructions for staff were "use twice a day as a moisturiser", but the chart had only been signed on five occasions during April. This meant people may not have received the amount of skin protection they needed.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed medicines being given to people. We heard people being asked if they were happy to take their medicines and if they needed any pain relief. We heard one person, who was in bed, being asked, "Are you ready for your medicines yet? Would you like me to bring them when you're up?"

Medicines were stored and disposed of safely. This included medicines that required additional security and medicines that required cool storage.

People and relatives told us they felt safe in the home. Comments included "I am safe here. I sleep all night, wake up at six o'clock, the staff come and help me. They come and check on me. If I want them, I ring the bell," "I never have to worry about my relative. They are safe here," and, "She is safe here. When she was at home she kept falling over. I was really worried about her. Now, I have no need to worry."

Staff understood what constituted abuse and the processes to follow to safeguard people in their care. Policies and procedures were available with details of useful contacts for staff. Staff told us they attended safeguarding training updates to refresh their knowledge and keep them up to date with any changes. A member of staff told us, "I've never seen anything really wrong with the care, but I would report if I needed to." The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Recent safeguarding concerns had been raised relating to the care people received. A protection plan had been submitted to the local authority safeguarding team following a meeting they held with the provider's management team in March 2018.

Accidents and incidents were recorded and incidents were audited to look for trends where actions could be taken to reduce recurrence. For example, for one person, their records included they, 'Suffers with postural hypotension and has a history of this type of fall. No injury sustained but due to frequent falls GP has referred to physiotherapists.' For another person the records stated they were afraid of falling. Their care plan instructed staff to make sure the person always had their call bell to hand and to make sure their room was kept as free from clutter as possible.

Where people were assessed as at risk of developing skin damage or who had pressure ulcers, pressure relieving mattresses and chair cushions were provided. The care records stated how often the person needed support to move, during the day, and at night. Some records were fully completed, however we also saw records that had not been fully completed and brought this to the attention of the registered manager at the time. Other risks to people's health and well-being were assessed and risk management plans were in place. These included risks associated with skin condition, choking, use of bed rails, falls, moving and handling, nutrition and dehydration.

Most of the people using the service, relatives and staff who commented about staffing levels told us that staffing levels were variable. The overall feedback we received was that staffing was sufficient in the week and the shortages were at weekends. Relatives said that at weekends, it often took more time to gain entry into the home, because usually there were, 'no management or reception staff' in the home. Other comments included, "You never see the same faces, especially at weekends." People using the service also told us that staff usually took longer to answer call bells at weekends.

We found that efforts were made to make sure sufficient numbers of staff were on duty, in accordance with the numbers determined by the provider's dependency assessment tool. However, significant shortfalls in the numbers of registered nurses employed meant there was continued reliance on the use of agency registered nurses. The registered manager told us agency staff often took overall responsibility for the management of the home at weekends, when the clinical lead nurse was not on duty. People using the service, relatives and staff expressed concerns about the weekend staffing arrangements with comments

including, "I come here twice a week, plenty of people around in the week, but weekends are a problem," "At weekends there never seems to be enough (staff)," "You never see the same faces, especially at weekends," and, "Doesn't seem to be any consequences especially when staff are late or don't even turn up at all, usually at the weekend." This all meant people did not always receive consistency in their care and treatment, which we found during our visit, and have reported on mainly in the effective and responsive sections of this report.

Staff were safely recruited. Staff files included application forms and proof of identity. One of the files contained one written reference. The provider's policy stated two written references were required. This oversight had not been picked up in the provider's quality assurance process. The second reference was obtained before the end of our visit. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. A business continuity plan was in place and this set out the procedures to be followed in the event of an emergency situation and people needed to be moved. This meant people could be confident their care needs would continue to be met in the event of such a situation occurring.

People were cared for in a clean, hygienic environment. During our visit, we looked in people's rooms, communal areas, bathrooms and toilets. People told us they felt the service was clean and well maintained. Staff told us that Protective Personal Equipment (PPE) such as aprons and gloves was readily available and on most occasions, we saw staff used PPE appropriately during our visit. Improvements had been made to the laundry facilities since we last visited the home. New equipment had been purchased and the area now provided clearly separated 'dirty to clean' workflow areas.

Requires Improvement

Is the service effective?

Our findings

The service remains Requires Improvement. When we inspected in March 2017 we found improvements were needed with recording people's consent to care. Improvements were also needed to make sure staff were suitably supported with staff supervision. At this inspection we found improvements had been made with regard to consent to care. Although plans were in place, improvements had not consistently been made to make sure staff were supported with supervisions. We also found shortfalls in the support and monitoring of people's food and fluids for those people at risk of malnutrition and dehydration.

Nutritional assessments were completed when people moved into the home and their dietary needs and preferences were recorded. We spoke with catering staff who told us how they were provided with each person's individual needs, choices and preferences which were recorded on diet notification forms.

People were assessed for the risks of malnutrition and dehydration. People's weights were monitored and analysed over periods of time and concerns were reported to the GP. Where needed, people were prescribed supplements and had food and fluid recording charts in place. However, we saw records were not fully or accurately completed.

Twelve people had been assessed as needing their food and fluids recorded and monitored. The monitoring charts instructed that, at the end of each day, at midnight, 'Daily intake to be assessed by person in charge. Record outcome in care plan.' We checked the recording for six people and found one person's records had been fully and accurately completed for the week leading up to, and on the days of our visit. For the five other records, details of the amounts of food eaten had not been recorded, one person's fluid chart was not completed at all for three days and another person's chart showed they had just 20 millilitres to drink over a 24hour period. Staff told us people had been supported as needed and had eaten and had drinks. One member of staff commented, "Staff must have forgotten to write it down."

One person was not given the support they needed. The person periodically stayed in bed during the day due to their increased frailty. On the first day of our visit, they stayed in bed all day. They did not receive the support with meals as their care plan stated was needed. In addition, their records were not accurately completed and did not reflect what they had actually eaten. Their care records stated they needed support to eat whilst they were in bed. We saw a bowl of mostly untouched porridge that was taken away from their bedroom during the morning. At 1pm we noted the person was trying to eat a lunch of potatoes and quiche from an over bed table that was at the side of their bed, and not directly in front of them. The person tried to reach the food, alternatively trying with a knife and fork, and then with their fingers. At 1.45pm, the person had eaten a small amount of potatoes and had barely touched the quiche. They gave up trying and placed the serviette onto the plate. We brought this to the attention of the registered manager. They confirmed the person always needed help and support if they were in bed. The following day we checked the person's recording chart for the previous day. It stated the person had a bowl of porridge for breakfast and quiche and potatoes for lunch. The records were not accurate and did not reflect what we had seen, and what the person had actually eaten.

The above was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed lunch in each of the areas of the home and to other people in their rooms. The dining room tables were laid in advance. People were offered and given clothes protectors if needed. There were choices of two main meals, and alternatives such as salads or omelettes if people chose not to have one of the main options. The meals were well presented and looked appetising. We saw many instances of people being supported with food and fluids, both in their rooms and in the communal areas.

People and relatives spoke positively about the food and were appreciated of what they described as 'recent improvements.' Feedback included, "This is home from home, the food is just like my wife used to make. Lovely," and, "All the food is brilliant. Whatever they make is really tasty."

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.

At this visit, we found people's rights were protected in accordance with the MCA. People were supported, with the support of relatives or advocates if needed, to make decisions. Staff checked with people to obtain consent and agreement to care whenever possible. One person told us, "They ask me what I would like to happen. They discuss options with me and we decide together the best way forward." Staff told us they had received training to help them understand the importance of acting in accordance with the requirements of the MCA.

People who lack capacity can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. At the time of our visit, one DoLS application had been submitted and the person was awaiting assessment by the local authority.

People and relatives told us they felt staff were knowledgeable and understood their needs and as one person commented, "The staff know how to look after me. I never worry." One person pointed out a relatively new member of staff and told us they had seen them being, 'checked on.'

Staff had received training that included safeguarding, food hygiene, fire safety, health and safety, equality and diversity and moving and handling. Staff completed an induction when they started working at the home. This included an initial week of training, then they were 'buddied' with experienced members of staff until they were competent and confident to work unsupervised.

Staff spoke positively about the training they received, although some care staff said it would be helpful to have more training to help them understand people's specific healthcare needs. They gave examples of specific illnesses that people in the home had. A visiting health professional told us, "The staff here ask for advice and they ask the GP to refer people to us. It's improved a lot." They also commented that staff listened to the advice that was given to them.

The registered manager told us about systems of staff development including one to one supervision

meetings and annual appraisals. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have. The registered manager told us most staff had not received regular supervisions in 2017. The staff we spoke with told us they had supervisions, 'from time to time,' but not as often as they would like. A supervision matrix for 2018 showed that out of 57 staff, 15 had not received any supervisions since the start of the year. This was not in accordance with the provider's policy that required staff to receive five supervisions each year and an annual appraisal. However, the registered manager shared their plan to make sure supervisions were back 'on track' for 2018, and senior staff had been allocated supervisor responsibilities. Most of the staff we spoke with told us that dates for their annual appraisals had been booked. However, there was a risk of people not receiving effective care because staff had not received sufficient support with supervision to monitor and enable them to carry out their roles.

Staff supported people to access healthcare appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed. A relative told us, "My relative became unwell and had an accident. They checked her over, called the doctor and sent her to hospital. They rang me straight away and kept me informed every step of the way." People's care records showed that people had been referred to and seen, for example, by GP's, the mental health team and physiotherapists.

Good

Is the service caring?

Our findings

The service remains caring. We received positive comments and feedback from people using the service and from relatives. These included "All of the staff are so kind. They help me out when I need help, always with a smile. They cut up my food so I can eat it myself," "The staff are really friendly. They are so kind to all of us, they always smile," and, "All of the staff are kind and considerate. They go the extra mile."

We spent time in various parts of the home, including communal areas and individual bedrooms so that we could observe the care, attention and support that staff provided for people. Everyone we spoke with told us that care staff were mindful of their privacy and dignity. We saw that staff knocked before entering rooms, and called to people using their preferred names or terms of endearment that were positively responded to. For example, we heard a member of staff knock on a person's door then call out, "Good morning sunshine. How are you today? Would you like me to pull your curtains?"

People's equality and diversity was recognised and respected. We heard staff communicating in ways that were meaningful to people. A member of staff commented, "I love it here and if I can do any extras I do. [Name of person] can't see, so it's really important that I knock, tell him who I am, then have a little chat."

Throughout the two days of our visit, we observed people being treated in kind, caring and respectful ways. Staff were helpful, warm and friendly and people looked relaxed and comfortable in their presence. One person told us, "Everything and everyone is good here. They ask you how you want to be looked after and then they do it for you-wonderful!"

Staff were able to describe people's likes, dislikes, interests and preferences. They told us they got to know people well, and as one member of staff said, "The staff and a lot of the residents here are from the local area. We all know the same people."

People's rights to a family life were respected. We spoke with visitors who told us they were made welcome at any time, with comments including, "The staff are lovely and nothing is too much trouble. They do everything with a smile."

People's confidential information was mostly protected. Care plans were stored in lockable cupboards and accessible to staff when needed. Daily monitoring records, such as food, fluid and repositioning records were kept safely in files in people's rooms. People also had notice boards just inside their rooms. We saw some of the boards had forms pinned on them headed, 'time and attendance.' Some of the entries staff had made did not promote people's dignity, was not respectful, and did not maintain confidentiality. For example, entries such as, 'pad changed' and 'nonstop buzzing' showed that staff were not writing in a person centred way. We brought this to the attention of the registered manager and the area manager at the time. They told us the use of the forms in this way were not necessary and immediately discontinued their use.

We read copies of compliments received in the home. An extract from one card read, 'Just wanted to say a

massive thank you for making Mum's first ever respite week so lovely. She had nothing but praise for you all with how you looked after her.'

Requires Improvement

Is the service responsive?

Our findings

The service remains Requires Improvement. When we inspected in March 2017, we found care plans did not reflect people's individual needs which was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection, we found the legal requirements had been met. The care plans overall, provided detail about how to meet people's individual needs. However, we also found, as we have reported in this section, further improvements were needed, for example, with regard to communication and responding to challenging or distressed behaviour.

Whilst the standard of care planning had significantly improved and reflected people's needs, they did not consistently show how to meet people's needs. For example, one person's records stated they communicated with picture or word cards. When we spoke with a member of staff they told us, "[Person's name] doesn't use anything. They point and we ask yes and no questions. They will also do a thumbs up and thumbs down response." Another person's records stated, 'Is able to communicate by using body language, putting his thumb up and down and nodding his head.' A member of staff told us, "They can speak. We have a laugh and a joke." The care plan for the person had been reviewed in February when it was stated 'there has been no change in communication needs.' This meant care records still did not always accurately reflect people's up to date and current care needs.

Care plans to support people with psychological and emotional needs did not provide enough detail for staff about how to provide support that may be needed. They were not written in a personalised or respectful way. For example, one person, it was recorded, was sometimes verbally aggressive with staff, and these occasions were recorded in the daily care notes. There was no guidance for staff about what they should say or do in these circumstances other than to record what happened and 'provide reassurance.' The daily records contained entries such as 'was very rude' 'went off on one' and shouting, using bad language.' There were two entries by staff in the recent records we looked at that described how they had supported the person, and on each of the two occasions they had spent 30 minutes providing support which had resolved the situation. It was not clear on other three occasions, how the person had been supported.

Most of the people we spoke with told us they were involved in discussions about their care needs, care planning or reviews. They also told us their preferences and choices were respected. One person said, "I read my care plan, asked for some changes to be made to reflect how I like things done. They made these changes then I signed the care plan as best I could to agree the plan. We agreed to have a look at it again next month." The senior staff we spoke with told us that currently, not everyone in the home participated in care reviews. They told us they were in the process of making sure everyone was offered the opportunity to be as involved as they would like to be.

Care plans provided details of people's physical needs. For example, one person's care plan included how they liked to have talcum powder and deodorant applied. It also stated that relatives preferred to shave the person when they visited each day. The care plan for another person with complex moving and handling needs provided clear instruction and details about the support they needed. This included how the hoist was to be used and how the person's legs were to be positioned. In addition, photographs provided further

guidance for staff. Whilst the guidance
was detailed and specific, people also told us that sometimes staff didn't pay attention to detail and as one person commented, "They carry out my care as I would want it. However, they don't quite finish me off. For example, everything is done but some staff forget to comb my hair."

Details of people's health care needs were recorded. For example, for a person with diabetes, their records included information for staff about how to support the person needed to maintain a healthy blood sugar and actions they needed to take if the person became unwell due to a high or a low blood sugar. For another person who had a catheter, their records provided clear guidance for staff, including the signs and symptoms the person may show if they were unwell.

We spoke with staff who told us they gained more knowledge and up to date information about people's current and changing needs at the staff handovers they attended. They told us they didn't read the care plans, "Often enough." One member of staff commented, "The plans have improved, but its still work in progress. They are more person centred that they were. We've worked hard to improve them." Most of the staff we spoke with told us they thought the care people received had improved compared to when we last inspected the home.

We saw activities were provided and the weekly activity programme was displayed in the home. The activity staff told us the activities regularly included visits from local mother and toddler groups, religious services, visiting entertainers and a weekly mobile shop. They told us they arranged one to one visits with people in their rooms when they were taking the mobile shop around the home. We received mixed feedback from people that included, "I never get bored here, there's always something to do" and, "I spend a lot of time watching TV in my room." The registered manager told us how they planned to enhance opportunities for people to socialise outside the home. One of the plans currently in progress was the installation of a gate to enable easy access to the bowling green next door to the home.

A complaints procedure was in place that was available to people and relatives. We spoke with one relative who had raised concerns. They told us, "This was brought to the attention of the manager and it soon got sorted out."

End of life plans were in place. However, the records were not always completed in full and did not always provide details about people's choices and wishes regarding their end of life care. For example, for one person, their record stated their 'condition was deteriorating, not for hospital admission.' This meant people could not be confident their end of life wishes and care needs would be met.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the home in March 2017 we identified shortfalls with risk management, person-centred planning, staff supervision and end of life care plans. We rated this key question as Requires Improvement. At this inspection, we found that whilst improvements had been made in some areas, these were not consistent. The provider had a range of quality assurance systems in place. However, these had not led to a consistently improved service for people living in the home. The service remains Requires Improvement.

We received an action plan from the provider following our last inspection. This provided details of how improvements were being made in response to shortfalls identified at that time. We found significant progress had been made in that many of the care records, overall, were written in a more personalised way. We also found further improvements were needed as we have noted in the responsive section of the report.

The provider had included, in their action plan, how they were going to ensure staff had the opportunity to attend supervision meetings in line with the provider's policy. In 2017, out of 65 staff, only three had received the number of supervisions required and in 2018, the records showed that 15 staff had not yet received a supervision.

We also found, as we have reported on in earlier sections of the report, shortfalls in the management of medicines and meeting peoples' nutritional and hydration needs.

A range of auditing and monitoring systems were in place. These included care and monitoring records, infection control, medicines management, pressure ulcers, falls and food safety. Audits were completed by the area manager, resident experience care specialist, registered manager and senior staff in the home. However, the shortfalls we found had not been identified and so improvement actions had not been taken. In addition, some audits we checked were not accurate. For example, the audit completed in March 2018 stated that 'the appropriate numbers and types of supervisions had been scheduled.' This was inaccurate as our findings have shown.

The above all shows the quality assurance systems in place were not effective in mitigating risks to people or to making consistent improvements in the service people received.

The above amounts to a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received positive feedback about the management of the home. Most people told us they saw the registered manager as they walked around the home and, as one person commented, "The manager is very good and leads the home well. She is very approachable. I always say the home is only as good as the manager and this home is excellent." We also received feedback about the lack of management presence at weekend, and one relative's feedback reflected what others told us. They said, "The manager leads the home well during the week, but at weekends it's a different story."

We found people were able to provide feedback. Surveys were completed, and people and relatives could enter feedback on an iPad in the reception area. Resident and relative meetings were held. The registered manager told us they were developing community relationships, such as those with the nearby bowling club and the local school, to create more opportunities for people to socialise within the local area.

The registered manager told us about the number of improvements they had made to the service since we last visited. This included the purchase of a new call bell system with a supply of pendants for people who wanted them for when they moved around the home. The staff room had been relocated, improvements had been made to the laundry facilities and a new treatment room had been created. They told us there had also been improvements to the care records to make them more person centred and in the dining rooms to make them more welcoming to people at mealtimes.

Staff had the opportunity to express their views at staff meetings. Minutes were recorded and circulated. In addition, 'colleague engagement surveys' were completed. The staff we spoke with told us they thought there was an issue with staff morale, with some staff telling us they felt there was an 'upstairs/downstairs divide' in the home. However, staff also told us they felt the service people received in the home was improving with comments including, "It's much better than it was before." Most staff commented they thought the lack of registered nurses was an issue that affected staff morale, with one member of staff telling us, "I wish the agency nurse on duty would stay with us." The registered manager told us they had recognised staff morale was an issue and this was on the proposed agenda for discussion at the next staff meeting.

The registered manager told us about the staff initiatives offered by the provider. These included , 'happy apps' which provided details of companies that offered staff discounts and various provider award schemes such as the Four Seasons Care Awards. Two members of staff were regional finalists in the most recent awards event.

The registered manager is a registered nurse. They told us how they kept up to date with current practice. They attended the provider's regional training days, one of which was taking place on the first day of our visit, and local care provider forums. They worked with, and received support from, the provider's area manager and resident experience care specialist.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.

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	People did not always receive their medicines safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People did not always receive the support they needed with food and fluids.

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	Quality assurance systems did not always identify shortfalls, mitigate risks or make improvements.