Shaw Healthcare Limited

Rotherlea

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?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 27 September 2018. Rotherlea 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.

Rotherlea is situated in Petworth in West Sussex and is one of a group of homes owned by a national provider, Shaw Healthcare Limited. Rotherlea is registered to accommodate 70 people. At the time of the inspection there were 60 people accommodated in one adapted building, over two floors, which were divided into smaller units comprising of ten single bedrooms with en-suite shower rooms, a communal dining room and lounge. These units provided accommodation for older people and those living with dementia.

The management of the home had been through a period of transition. The home had a registered manager who had been on long-term leave from work. A registered manager is a '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 home is run. The management team consisted of team leaders and two deputy managers, one of whom was also on long-term leave from work. A manager from one of the provider's other homes had been managing Rotherlea, alongside their own service. An operations manager also regularly visited and supported the management team.

At the last inspection on 14 and 15 September 2017, the home received a rating of 'Requires Improvement'. The provider was found to be in breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the last inspection, the provider completed an action plan to inform us of what they would do and by when to improve the key questions of safe, effective, responsive and well-led to at least good. This was because there were concerns about staff's understanding and use of the Mental Capacity Act 2005 (MCA). The provider had not always complied with the Deprivation of Liberty Safeguards (DoLS). Staff were not always provided with consistent guidance about people's specific healthcare needs. Records to document the actions of staff were not always maintained. Areas identified as needing improvement related to following advice that had been provided by external health care professionals.

At this inspection, we found some improvements, in relation to MCA, the maintenance of some records and implementing healthcare guidance, had been made since the previous inspection. However, people were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible. The policies and systems in the home did not always support this practice. This was an area of concern.

One person's needs had been assessed before they moved into the home. This had shown that they had a history of falls. The provider had failed to ensure that these risks were identified and managed to assure the person's safety. The person had fallen and sustained a significant injury. This was an area of concern.

There were continued concerns about the provider's oversight and overall ability to maintain standards and to continually improve the quality of care. Not all concerns that had been identified at the previous inspection on 14 and 15 September 2017, had been addressed. Areas that were identified as part of this inspection had not always been picked-up and acted-upon by the provider's own quality assurance audits.

Records, to document people's specific healthcare conditions did not always contain sufficient guidance to inform staff's practice. It was not always evident how people or their relatives had been involved in contributing or reviewing their care.

We made a recommendation about people's access to meaningful activities, interaction and stimulation.

People were cared for by sufficient numbers of staff to meet their physical needs. People were protected from harm. Staff knew the signs and symptoms to look for if there were concerns about a person's care. Reflective practice ensured that lessons had been learned when care had not gone according to plan.

Most risks were managed and people received safe care. People told us they felt safe. One person told us, "I feel safe because there are people around and the bell". A relative told us, "I feel my relative is 100% safer here".

Medicines were managed safely. People were protected from infection and staff demonstrated correct techniques to ensure that cross-contamination was minimised.

People had access to healthcare professionals when they were not well. There was a coordinated approach to people's healthcare. One person told us, "If I wanted to see a GP I would only have to ask a team leader".

People's hydration and nutrition was maintained. Comments from people included, "The food is wonderful" and "My food is OK, I have no complaints. If you want more you only have to ask".

People and their relatives were informed about their care. People told us that staff were kind, caring and compassionate. Comments from people included, "The carers are fine, no problem with any of them" and "They are very pleasant and helpful carers".

People's privacy and dignity was maintained. People were supported to remain comfortable at the end of their lives.

People were aware of how to raise concerns and complaints. Residents' and relatives' meetings, as well as surveys enabled people to voice their opinions and suggestions about the way the home was run.

People had space to be with others, spend time on their own or enjoy the gardens in warmer weather.

People, relatives and staff were complimentary about the management of the home. People and their relatives told us that they could approach the management if they had queries about people's care. One person told us, "I don't know who the actual manager is here. However, there seems to be plenty going on and is run pretty well". Staff felt valued and appreciated and told us that morale had improved.

This is the third consecutive time that the home has been rated as Requires Improvement. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any

representations and appeals have been concluded.

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 home was not consistently safe.

Risks to people's safety had not always been considered, identified or assessed.

Sufficient staff ensured people's physical needs were met. People were protected from abuse. Staff knew the procedures to follow if there were concerns regarding a person's safety.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The home was not consistently effective.

The provider had not always worked in accordance with legislation when people were deprived of their liberty.

Staff did not always have the necessary skills to meet people's specific healthcare needs.

People's needs had been assessed. Their healthcare needs were met.

People had enough to eat and drink. They were complimentary about the food.

Is the service caring?

Requires Improvement

The home was not consistently caring.

People and their relatives were not always involved in decisions that affected their care.

Staff were kind and caring.

People's privacy and dignity were maintained and their independence promoted.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

Not all people had access to activities and stimulation. People were not always supported to engage in meaningful activities, interaction or stimulation.

People and their relatives were made aware of their right to complain.

People could plan for their end of life care.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

There was a failure to continually improve the service.

The provider's quality assurance processes had not always identified the shortfalls that were found at the inspection.

Feedback about the leadership and management of the home was positive.

Rotherlea

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 home, and to provide a rating for the home under the Care Act 2014.

This unannounced inspection took place on 27 September 2018. The inspection team consisted of two inspectors and two experts-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. In this case the experts-by-experience had experience of older people's services.

Before this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications and an action plan that the provider had sent us. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). This was because the inspection was unannounced and we were inspecting the home to ensure that the concerns found at the last inspection on 14 and 15 September 2017, had improved. A PIR 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.

During our inspection we spoke with 14 people, three relatives, eight members of staff, the deputy manager, the operations manager and a representative from the provider's quality assurance team. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and medicine administration records for nine people, four staff records, quality assurance audits, incident reports and records relating to the management of the home. After the inspection we contacted an external social care professional for their feedback.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the care and support people received as well as the lunchtime experience and the administration of medicines.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 14 and 15 September 2017, an area that needed improvement was identified. Staff had not always followed the guidance that had been provided by external healthcare professionals. One person had been assessed as being at a high-risk of choking and required their drinks to be thickened. Staff's understanding of this was not consistent. Observations showed that the person did not always have access to thickened drinks. At this inspection, improvements had been made and this had now been addressed. Staff understood people's individual needs. People, who required their drinks to be thickened, had access to these. At this inspection there were concerns about the assessment of risk.

Risks to most people's safety had been identified and assessed. Staff were provided with guidance about how to keep people safe. Although, people were not always sufficiently protected from harm. A pre-assessment which had been completed before one person moved into the home, showed that they had a history of falls. The providers guidance, when people have a history of falls is to complete a falls risk assessment and falls prevention care plan within four hours of them moving into the home. This is to ensure that any risks are identified and mitigated. Staff had failed to do this and had not considered the risks or taken measures to mitigate them in a timely way to assure the person's safety. Records showed that the person had experienced a fall and sustained a significant injury, five days after moving into the home. It was not evident how the person's needs and associated risks had been considered before this. After the fall and significant injury, the person had been assessed as being at a very high-risk of falls. Appropriate precautions had been implemented to minimise the risk of reoccurrence. This included providing a sensor mat so that staff were alerted if the person attempted to stand. When the provider was asked why they had failed to assess and mitigate the risk, prior to the person's fall and subsequent injury, they explained that it had been an oversight and should not have happened. Once we had made them aware of the failure to assess the risk prior to the person's fall and significant injury they reviewed the incident and made a safeguarding referral to the local authority.

The provider had not assessed risks nor had they done all that was reasonably practicable to mitigate any such risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were at high-risk of choking had been assessed. Thickeners had been prescribed to thicken people's drinks to minimise the chances of them choking. On 6 February 2015, NHS England issued a patient safety alert on the risk of death by asphyxiation by accidental ingestion of fluid or food thickening powder. It advised the safe storage of thickeners. Thickeners that were used for people who lived in one part of the home were stored in a locked cabinet. This ensured that people could not have unsupervised access to the thickeners and minimised the risk of harm. In another area of the home, thickener was not stored securely and instead was kept in an unlocked kitchen cabinet that people could access. When this was fed back to the provider, they acknowledged that this was not good practice and advised that the thickener would be stored securely immediately.

People were supported by staff who were safe to work with people at risk. Pre-employment checks had been

conducted as well as staff's employment history and references obtained. People had access to sufficient staff to meet their physical needs. When people called for staff's assistance they received this in a timely way. Consideration of staff's skills and levels of experience were made. New or temporary staff were allocated to work alongside existing staff to ensure that they were supported to have a good awareness of people's needs.

People were protected from abuse and discrimination. People told us that staff made them feel safe and that being at the home made them feel secure. Comments from people included, "I'm looked after well, I don't think they could do any better", "I feel safe because there are people around and the bell" and "I really like it here. Having people close-by makes me feel safe and happy". Staff knew how to identify signs of abuse. They were aware of how to raise concerns about people's wellbeing and safety. People told us that they felt comfortable to raise concerns with staff and were confident that these would be listened to and acted upon. When there had been concerns about people's wellbeing, the management team had either raised these to, or worked with, the local authority to ensure people's safety and wellbeing was maintained.

Staff ensured that practices that restricted people's freedom were minimised. Staff treated people equally. One person, who was living with dementia, demonstrated signs of apparent anxiety and distress. Staff supported them appropriately, they used distraction techniques and interacted with the person, to minimise the person's anxiety and diffuse a potentially challenging situation.

Accidents and incidents that had occurred had been recorded, monitored and analysed to identify trends. Information from the analysis was used to inform staff's practice and supporting documentation. For example, risk assessments and care plans were updated to reflect changes in people's needs. Lessons had been learned from an incident that had occurred at one of the provider's other homes. As a result of a fall that one person had experienced, the provider had introduced a 72-hour post-fall observation record. They had also revised their policy to provide clear guidance for staff with regards to how to respond to injuries.

People had access to equipment that was safe. This was regularly checked to ensure people's safety. Infection control was maintained and the home was clean. Staff used personal protective equipment when supporting people with their personal care needs. They disposed of waste appropriately to minimise the risk of cross-contamination.

Records showed some people had been involved in the assessment of risk. People, when appropriate, had been able to take appropriate risks to retain their independence. For example, some people self-administered their own medicines. Medicines were managed safely. People were supported to take their medicines by trained staff. Staff were respectful when administering medicines and involved people in the process, explaining their actions and respecting people's wishes when they refused medicines. There were clear guidelines for staff to follow, as well as information that could be passed to other healthcare professionals if a person had to transfer to another setting. Guidance identified people's needs and preferences and informed staff of how to administer people's medicines safely. People had access to their medicines when they needed it. One person told us, "Yes, I get mine on time. You can always ask if you want something for a headache".

Staff ensured that people's behaviour was not controlled by the excessive use of medicines. One person, who at times displayed behaviours that challenged others, had been prescribed medicine by their GP. Staff were mindful of the impact of the medicine on the person's behaviour. They had liaised with external healthcare professionals and had acted to ensure that they were not having too much.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 14 and 15 September 2017, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some people had a condition that had the potential to affect their decision-making abilities. Staff had not always assessed people's capacity in relation to specific decisions. They had sometimes made decisions on people's behalf without involving others that were involved in their care and therefore some people had been deprived of their liberty unlawfully. At this inspection, some improvements had been made and the provider was no longer in breach of this regulation. Staff had a better understanding of MCA. When people had a condition that had the potential to affect their decision-making ability staff had assessed their capacity in relation to specific decisions. Relevant people, involved in people's care had been consulted and decisions were made collectively and in people's best interests.

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 make 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 are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection, some people were being deprived of their liberty unlawfully. Records showed that some people had a condition which had the potential to affect their decision-making ability. Most people required constant support and supervision from staff. The provider had not always taken appropriate action when people were unable to consent to this. They had not always made DoLS applications to the local authority. Nine people had a DoLS authorisation. One of the DoLS had expired by over one week and the provider had not ensured that a reapplication was made in a timely way to ensure that the person was not being deprived of their liberty unlawfully. When this was fed back to the management team they explained that this had been an oversight and that appropriate applications to the local authority would be made.

Although the provider was now working in accordance with the MCA and had met the previous breach of Regulation 11. People were deprived of their liberty for the purpose of receiving care and treatment without lawful authority. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were confident in staff's abilities. Staff had access to an induction and on-going training which the provider felt essential for their roles. Links with external healthcare professionals were maintained to provide additional sources of support for staff. Staff felt that they had access to training that enabled them to carry out their roles.

Staff told us that they felt well-supported by the management team. They spoke of a more-improved staff morale. Staff told us that the management team were helpful and approachable. Staff received regular

supervision to receive feedback on their practice and enable them to identify any learning and development needs.

Communal areas as well as private bedrooms, provided people with different spaces to meet their needs. Communal areas were light, bright and spacious and enabled people to mobilise from one area of the home to another. People could personalise their bedrooms with paint colours, furniture and ornaments that were important to them. When people were living with dementia, signs and memory boxes were located beside their bedrooms. These contained photographs or items that were important to them. A member of staff told us, "Those are to help remind people where they sleep".

People's needs were assessed before they moved into the home. Care plans provided staff with guidance about people's health conditions. People's skin integrity and their risk of developing pressure wounds was assessed. For people who had wounds, regular monitoring took place and appropriate treatment provided by community nurses. Appropriate equipment to relieve pressure to people's skin, such as specialist cushions and air mattresses were used, as well as regular support from staff to frequently reposition.

People were supported to lead healthier lives and their health was maintained. Staff recognised when people were not well and worked with external healthcare professionals to ensure people received coordinated care. Timely referrals had been made to the GP and other external healthcare professionals when there were concerns over people's health. People, and their relatives were informed about decisions so that they were aware of how their health was being managed. One person told us, "Yes I have seen a Doctor here when I needed it. They say would you like to see a Doctor? If you're unwell".

People had sufficient quantities to eat and drink. People were complimentary about the food. They told us that they had choice and that staff respected their right to change their mind if they disliked their original choice. One person told us, "They tell me what's on the menu and I choose. If I don't like the choices I can ask for an omelette and they bring a nice little bowl of salad with it".

Staff were mindful of supporting people, who were living with dementia, to make choices. Although people were asked for their meal choices the day before, staff served two meals and showed these to people so that people had a visual aid to make their choice. When people required assistance to eat and drink, staff supported them appropriately, with sensitivity and patience. People had a positive mealtime experience. They could choose where they are their meals. Some people preferred their own space, whereas others chose to eat with others. The mealtime was sociable and relaxed.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff were thoughtful, compassionate and caring. Comments from people included, "The care here is better than where I was before, it's the staff and the team leaders that make it better", "The majority are very good, they treat me very well. There is one carer who is exceptionally good, always has time" and "They're marvellous the way they treat you". Despite this, we found an area of practice that needed to improve.

Records showed that relatives had been informed if there had been changes to people's needs or care requirements. It was not evident how people or their relatives had been actively involved in discussing people's care needs or in devising or reviewing their care. People were asked about how they were involved in their care and how they had contributed to any plans about their care. A relative told us that they had been asked about their loves one's preferences when they first moved into the home. However, some people told us that they had not been involved in discussions about their care needs or if they were happy with the care they received. Other than people's initial assessment of their needs, records did not show how people or their relatives had been involved in on-going discussions about people's care needs. This was an area of practice that needed improvement.

People could have access to advocacy services if they required assistance to make their needs known. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

Staff were friendly and courteous when they interacted with people. Some people engaged in banter with the staff and were observed to be smiling and laughing with them. People told us that they were fond of the staff. Information about people's life history, their hobbies and interests had sometimes been gathered and were documented in care plans. Staff told us that they used this to gain an awareness of people's lives before they moved into the home. People were cared for by staff that knew them well.

Two people were displaying signs of apparent anxiety. They were calling out to staff and showing signs of distress. Staff adapted their approach to offer appropriate support. They spent time talking with them, distracting them and offering practical support, such as showing them where their bedroom or toilet was.

People were treated with respect. Staff supported people with tact and sensitivity when supporting them with their personal care needs. People's privacy and dignity was maintained. Staff knocked on doors and waited for an answer before entering people's rooms. People could choose the gender of staff and told us that this was listened to and respected. Staff took time to explain their actions before offering support and fully involved people in their care.

People's privacy, with regards to information that was held about them, was maintained. Records were stored in locked cabinets and offices and conversations about people's care were held in private rooms.

People, could remain independent. Some people administered their own medicines, whereas others were

observed preparing drinks in the kitchenette areas of the home. One person told us, "They let me do what I want to do. If I need help I ask for it".

People's diversity was respected and people were treated as individuals. Staff adapted their approach to meet people's needs and preferences. People maintained their identity and they wore clothes of their choice. Information about people's religious preferences was documented in their care plans. People had access to regular visits from religious groups and could choose if they took part in these. People told us that staff respected their preferences.

People could maintain relationships with those that were important to them. Relatives told us that they could visit at any time. A relative told us, "They do welcome you here, definitely".

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 14 and 15 September 2017, it was not evident if people had access to activities to occupy their time if they wanted. Records to document this were not always maintained. At this inspection, records to document people's engagement had improved. However, there were concerns that not all people had access to meaningful activities or stimulation. People's life history, backgrounds and interests had sometimes been documented in their care plans. Staff told us that this was helpful as it provided them with an insight into people's lives before they moved into the home.

It was not apparent how information about people's backgrounds and hobbies was used to promote pastimes that were of interest to people. People had mixed experiences and access to stimulation and meaningful activity. The provider employed two activities coordinators who worked six days per week. Planned, group activities were offered to some people such as quizzes, arts and crafts, church groups and external entertainers. There had also been some trips to the local park and there were plans for some Christmas shopping days. Observations showed some staff taking time to interact with people who were living on the residential units.

Feedback from people was mixed. Some people told us that they liked the activities that were provided. Comments from people included, "You can go to cooking sessions and there's a girl who comes in to sing" and "I like to take part in the exercises sometimes". Other people thought that they were too child-like. One person told us, "Some of the things they do are a bit childish".

Some people, were living with dementia and were therefore more dependent on staff to provide opportunities for stimulation to occupy their time. We observed that for some people, they spent large amounts of their time in the same position, with little stimulation or interaction from staff other than to provide for their basic care needs. Some staff were busy and task-focused and there were, at times, missed opportunities for conversation and interaction with people. Most people, who were living with dementia, were observed to be unengaged or sleeping. Without exception, people and their relatives told us that staff were compassionate and thoughtful. Although they felt that staff were often too busy to sit and talk with them. Comments from people included, "Now and again the carer's come for a chat", "They talk as they're passing" and "One or two of the carers are sometimes a bit rushed". Although there were sufficient staff to meet people's physical needs, the provider had not ensured that there were sufficient staff to meet people's emotional and social needs.

Some people, due to choice or their health condition, spent their time in their rooms. This meant that they were more at risk of being socially isolated. Some people told us that they were happy to watch their televisions or read their newspapers. Staff told us that they took time to interact with these people when they served their meals or supported them with their personal care needs. Records to document people's access to stimulation did not demonstrate that people had sufficient access to meaningful activities or interests. One person, who spent their time in their room told us that they never knew what activities were happening in the rest of the home. They also explained that staff did not spend time with them in their room as they would have liked.

We recommend that the provider seeks information and guidance from a reputable source on meaningful stimulation, interaction and engagement.

People were provided with a call bell so that they could call for assistance from staff. For people who were unable to use a call bell, due to their capacity and understanding, pressure mats were used so that when people mobilised staff were alerted and could go to people's aid. Regular checks were also undertaken to ensure people's safety when they were in their rooms.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 25 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Staff ensured people's communication needs had been identified at the initial assessment and formed part of their care plans. These documented the best way to communicate with people. Information for people and their relatives, if required, could be created in such a way to meet their needs and in accessible formats to help them understand the care available to them.

People were made aware of their right to raise concerns and complaints. Posters were displayed and people had been made aware of the complaints procedure when they first moved into the home. Regular meetings and surveys provided opportunities for people and their relatives to make their feelings known. People told us and records confirmed, that people could speak freely and air their views and concerns. People told us that they were happy with the care they received. People and their relatives told us that they would feel comfortable raising concerns. When people or their relatives had done this, records showed that the provider had taken appropriate and timely action to deal with these.

People were provided the opportunity to plan for their end of life care. People had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. Some people did not want to discuss this and staff had respected their wishes. Records for one person, who was being cared for at the end of their life, showed that they were being supported according to their previously expressed wishes.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 14 and 15 September 2017, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns about the management of records to document people's care needs and the actions of staff. At this inspection, some improvements had been made, records to document people's food and fluid intake as well as the frequency they had been supported to reposition, were completed in their entirety. We did however, continue to have concerns about the maintenance of other records and the provider's overall ability to maintain standards and continually improve.

Care plans for most people were personalised and detailed and provided specific guidance for staff. The previous concerns in relation to consistent information about the management of some people's diabetes, remained an area in need of improvement. One person, who had diabetes, had detailed guidance to inform staff's practice. It advised of the signs and symptoms to look for, as well as the appropriate action to take if the person's blood glucose levels became too low. However, for others, whose health condition was treated with medication that had the potential to rapidly alter their blood glucose levels, staff were not provided with clear and detailed guidance to inform their practice. When this was fed back to the provider they explained that they would act to ensure that staff were provided with clear and consistent guidance.

The management of the home had experienced a period of transition. The registered manager had been on long-term leave from work. A manager from one of the provider's other homes had been managing the home alongside their own service. There were two deputy managers, one of whom was on long-term leave from work. An operations manager regularly visited the home to conduct quality assurance audits and to offer support.

There are concerns about the provider's oversight and overall ability to maintain standards and to continually improve the quality of care. Concerns that had been identified at the previous inspection on 14 and 15 September 2017, had not always been addressed. This related to the management and oversight of DoLS applications and authorisations. As well as staff not being provided with consistent guidance about people's specific healthcare needs.

Quality audits conducted by the management team and the provider were not always effective in identifying and resolving areas in need of improvement. Areas that were identified as part of this inspection had not always been picked-up and acted-upon by either the manager's, operations manager's or the provider's own quality assurance audits. These included, the untimely assessment of risks to ensure people received safe care. Some people were being deprived of their liberty unlawfully. Records, to document people's specific healthcare conditions did not always contain sufficient guidance to inform staff's practice. It was not evident how people or their relatives had been involved in the on-going review of their care. People did not have sufficient access to meaningful activities, interaction and stimulation to occupy their time. This demonstrated that the provider lacked sufficient oversight to ensure that the systems and processes as well as the practices of staff were meeting people's needs.

Areas that the provider had identified as needing improvement within their audits, had not always been completed. For example, an audit had been completed three months before our inspection by the provider's quality assurance team. It had identified that the CQC action plan from the previous inspection needed to be followed, that DoLS applications and resubmissions needed to take place and that staff needed to document when people or their relatives had been involved in discussions about people's care. At this inspection, these continued to be areas of concern and it was not evident what action had been taken to address these identified actions.

There were continued concerns with regards to the oversight of systems to ensure people received appropriate care. The home has been rated as 'Requires Improvement' for a third consecutive time. The provider had not ensured that they maintained an accurate, complete and contemporaneous record for each person. They had failed to ensure that they assessed, monitored and improved the quality and safety of the services provided. This included the experience of people receiving a service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff told us that they found the management team to be helpful and approachable. A relative told us, "I don't know who the actual manager is here. However, there seems to be plenty going on and its run pretty well". People and their relatives could raise concerns and have an input into the running of the home. Regular residents' and relatives' meetings were held. These enabled people to be kept informed of what was happening at the home. Attendance at the meetings was low, however, people and their relatives told us that they felt able to approach the management team if they had any queries or concerns. Surveys were sent to people and their relatives to gain their feedback so that the provider was aware of their experiences. Results of a recent survey showed positive responses.

Staff told us that morale had improved and that they felt valued and appreciated. Regular supervision and staff meetings enabled staff to be provided with feedback about their practice and to be kept informed about the running of the home. They told us that they felt able to share new ideas and suggestions and that these were respected. Records showed that any learning from incidents had been reflected upon and shared with staff to ensure improvements were made. The provider continued to recognise the importance of valuing and empowering staff through their own national STAR awards. These recognised staff who demonstrated excellence.

People and their relatives told us and records confirmed, that the manager and provider demonstrated their awareness of the duty of candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.

Links with external healthcare professionals and local authorities had been developed to ensure that people received a coordinated approach to their care and staff learned from other sources of expertise.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. The registered person had not ensured that service users must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.

The enforcement action we took:

A warning notice has been issued as the provider had not ensured that care and treatment was provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The enforcement action we took:

A warning notice has been issued as the provider had not ensured that they assessed, monitored or improved the quality and safety of the services provided.