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Engleburn 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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Engleburn Care Home on 28 and 29 April 2016 and 6 May 2016.

Engleburn Care Home is registered to provide nursing care for up to 76 older people, some of whom live with dementia. There were 68 people living at the home at the time of our inspection. The home is separated in to two units. Engleburn provided support for people who were more independent. Foxholes provided care and support for people with more advanced dementia.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 registered manager currently managed the home with the support of two deputy managers. They also managed a second home belonging to the provider and had identified that it was difficult covering two large homes. New management arrangements had been put in place to take effect from June 2016 which included the appointment of a new manager to take full time responsibility for Engleburn Care Home.

We received mixed feedback from people and relatives during the inspection, with some saying they had a positive experience of receiving care whilst others less so. We also identified inconsistent quality in the delivery of care, safeguarding, record keeping and monitoring systems within the home.

People were not always protected from possible abuse. Staff were able to identify some signs of abuse and understood who to report concerns to within the home. However, staff had not identified that unexplained bruising could be a sign of abuse and a number of such incidents had not been investigated and had gone unreported to the local authority and to CQC.

We received mixed feedback about the level of staffing and whether it was sufficient to meet people's needs. Staff told us they thought there were enough staff most of the time but some staff said there could sometimes be pressure points in the day, such as early mornings. People and relatives said they thought there were times when there were not enough staff and gave examples of times when care had been delayed.

Staff interacted positively with people when they delivered care. We observed staff showing kindness and re-assurance to people when they became upset or worried and people's dignity was respected by most staff. However, we observed other care practices and written notices around the home which did not always refer to people with dignity and respect.

Staff regularly involved people or their relatives in reviewing their care plans. Reviews took place on a regular basis or when someone's needs changed. However, we found some examples of care plans which were out of date and did not reflect people's most current circumstances or support needs. Health

professionals visited the home regularly to provide advice and treatment when necessary. However, it was noted that not all staff were able to identify when people needed medical advice or treatment in a timely way.

Staff received induction and training in a range of areas to support them to meet people's needs. However, there were some key areas of training which had not been kept up to date by all staff, such as safeguarding people from abuse.

The home worked with health and social care professionals and family members to ensure decisions made in people's best interests were reached and appropriately documented. However, some staff were not sufficiently knowledgeable about the requirements of the Mental Capacity Act 2005 (MCA) to be able to explain how to safeguard people's best interests and the MCA was not always implemented correctly.

The management team understood about the deprivation of liberty safeguards (DoLS) and submitted applications to the local authority for DoLS where appropriate. Some applications were still waiting to be processed by the local authority.

People received a choice of food and drink to meet their specific choices and dietary needs and where required, were assisted by staff to eat their food. However, some people told us their food was often cold.

The home employed activities co-ordinators to provide opportunities and help encourage people to participate in activities. Most people's records documented their hobbies, interests and described what they enjoyed doing in their spare time. However, arrangements were not always in place to ensure people who preferred to stay in their rooms or who were unable to join activities in the lounge had regular opportunities for activities or social interaction.

People and relatives were given opportunities to provide feedback, compliments and comments. Some people and their relatives told us they knew who the registered manager was and felt able to raise concerns with them or the deputy managers. Others told us they did not know who the registered manager was and never saw them. We observed during the inspection that the registered manager spent most of their time in their office whilst the deputy managers provided supervision and guidance to staff.

The home had a range of audits in place to help monitor the quality of the service. However, not all of these were effective as we identified a number of areas of concern which their audits had not picked up, such as inaccuracies and discrepancies in record keeping. When we raised this with the registered manager and deputy managers they put systems in place to address this in future, but it was too soon to assess these for effectiveness.

Medicines were managed, stored and administered safely. People were asked for consent before receiving their medicines and accurate records were maintained.

We found 5 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 1 breach of the Care Quality Commission (Registration) Regulations 2009.. You can see what action we have told the provider to take in the main report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from the risk of abuse because staff did not always recognise potential concerns or report them as required. Potential risks to people's health were not always identified or assessed appropriately.

There were not always sufficient staff on duty to meet people's needs in a timely way, although the home was continually trying to recruit.

There were appropriate arrangements in place to manage, store and administer medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective. The provider had a training programme in place for staff. However, some training was out of date and staff lacked knowledge in key areas such as the Mental Capacity Act 2005, which was not always consistently applied.

People were supported to maintain their health and had access to healthcare professionals when required. However, it was noted that some staff did not always identify health concerns in a timely way.

Where potential restrictions on people's liberty had been identified, appropriate applications had been made to the local authority under the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not always caring. Some care practices and notices around the home did not refer to people with dignity.

Most people told us staff were helpful and kind and we observed staff providing compassionate care and reassurance to people.

People were supported to make choices and staff promoted their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were reviewed regularly. However, these were not always updated to reflect people's up to date circumstances.

People told us they knew how to complain and who they would speak to if they had a concern. However, we noted some responses to complaints were unhelpful and unprofessional.

Most people and relatives were involved in writing and reviewing care plans which reflected people's choices.

Is the service well-led?

Requires Improvement

The service was not always well-led. Audits were not always effective in identifying issues of concern or for improvement and record keeping was not always accurate. The provider had not always notified the commission of certain incidents and events as required by law.

Most people told us knew the deputy managers, although other people and relatives told us they did not know who the registered manager was and never saw them.

Staff, people and relatives were provided with a range of opportunities to provide feedback, and to be involved in developing the service.

Engleburn 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.

The first day of the inspection took place on 28 April 2016 by a lead inspector and was unannounced.

We returned to continue the inspection on 29 April with an inspection team which consisted of the lead inspector, a second inspector and a specialist nurse adviser who had experience of working with older people living with dementia. The lead inspector concluded the inspection on 6 May 2016.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the CQC. A notification is when the registered manager tells us about important issues and events which have happened at the service. Before the inspection the provider completed 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 plan to make. We used this information to help us decide what areas to focus on during inspection.

We spoke with twelve people who use the service and eight relatives who were visiting. We spoke with seven care staff, an activities co-ordinator, a chef and the two deputy managers as well as the registered manager, a visiting GP and two other health professionals. We carried out observations throughout the inspection in both lounges and dining rooms and chatted to people in their rooms. We reviewed ten people's care plans and pathway tracked five people's care to check that they had received the care they needed. [Pathway tracking shows us what treatment people received and the outcome for the person. We do this by looking at care documents to show what actions staff had taken and who else they had involved such as a GP.] We looked at other records relating to the management of the service, such as medication, quality assurance systems and policies, and seven staff recruitment, training and supervision records. Following the inspection we spoke to a care professional and a fourth health professional by telephone to gain their views. We also gathered further feedback from staff by way of questionnaires, 8 of which were completed and returned to us.

Requires Improvement

Is the service safe?

Our findings

Most people and their relatives told us they felt safe at Engleburn Care Home, however, we received mixed responses from people and relatives when asked if staff came quickly when they asked for help. Some people said they didn't have to wait for staff, and others said there were often delays in receiving the help they needed because staff were too busy. For example, one relative said "It can be an hour that [My relative] has to wait for the toilet" and another person said it could often take "A long time to be helped at this time of the morning" when staff were trying to get everyone up. Another person told us the length of time it took staff to answer the call bell was "Annoying." A care professional said "I have found it difficult to find a member of staff. Sometimes there is a lack of staff, other times not. It varies." A relative told us "The carers are excellent although they appear to be hard pushed at times to get tasks completed."

Most staff told us they thought there were sufficient staff on duty to keep people safe although others said there were times when they felt pushed, especially in the mornings. For example "We found there were not always sufficient staff deployed. During our inspection we observed there were times when there were ample staff around but other times when there were no staff visible in communal areas to supervise people. We discussed staffing levels with the deputy managers and registered manager and heard that a number of staff had left recently and they were trying hard to recruit to the vacancies. The home was using regular agency staff to try to cover the vacancies in the short term. We looked at the rotas for April and saw that on some days the staff rostered on duty exceeded the assessed number needed, but on other days staffing did not meet the number required.

People were not always protected from the risk of abuse because staff had not always identified possible abuse. For example; unexplained bruising. In two people's care records, significant, unexplained bruising had been recorded on a body map. These incidents had not been investigated for a cause, and had not been reported to the local authority safeguarding team or CQC. Incidents of physical and verbal confrontations between people had not always been identified as abuse and had also not been reported. We spoke with the registered manager about this who told us they would send us a notification each time there was one of these incidents, but said we would be inundated. We confirmed this was the appropriate course of action. The management team told us that when they did make a report to the local authority safeguarding team, they kept a record in people's individual care files. They were therefore unable to maintain an overview of the safeguarding concerns within the home.

The training records showed that half of the staff employed at the time of our inspection had not received safeguarding training which was due in 2015, and this had not been identified by the management team as overdue. Therefore safeguarding training had not been included in the upcoming training programme booked by the deputy managers. The safeguarding policy required clarification for staff about the types of abuse to look for and when and who to report to. The whistleblowing policy and procedure informed staff that any concerns should be reported internally and the investigating officer would decide if it should be reported externally. This contradicts the purpose of a whistleblowing procedure, which should also empower staff to report concerns about poor practice to an external organisation such as CQC or the local authority. When asked, some staff did not know who to report safeguarding concerns to outside of the home

if they needed to. We brought this to the attention of the registered manager, who amended the policies the same day. However, the new policies still needed to be brought to the attention of staff.

This was a breach of regulation 13 of the Health and Social Care Acct 2008 (Regulated Activities) Regulations 2014; Safeguarding service users from abuse and improper treatment.

Risks to people had not always been identified and managed appropriately. For example; some people had had a number of falls and although these were recorded as incidents or accidents, individual falls logs were not completed to maintain an overview for each person. Staff could therefore not analyse falls appropriately to identify any trends, such as a similar time of day or location of falls. One person had 18 falls between 26 July 2015 and 18 December 2015 but there was no analysis of why these falls had occurred and no record of involvement of other professionals such as a referral to the falls co-ordinator and no falls risk management plan. We noted that other people who were at risk of falls did not have a falls care plan or risk assessment to guide staff in how to minimise the risk of the person falling.

Records did not demonstrate that staff undertook appropriate assessment before moving people when they said they were in pain following a fall. We asked the registered manager about this and they told us staff would always get a Head of Care to make an assessment before moving someone. On one occasion we observed staff assisting one person up from the floor with the aid of a hoist. The person was complaining of pain in their back but staff did not seek advice from a Head of Care before moving them. When we asked the staff member what they would usually do if they found a person on the floor complaining of pain, they told us they would do the assessment, checking leg lengths, asking them if they could move their legs, and asking questions to assess the situation before moving them. When we asked about the person we had observed being hoisted, they said they had done the checks, knew the person well and they always had back pain which was normal for them. We discussed this further with the registered manager as staff had not followed the procedure they had described to us.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014; Safe care and treatment.

Arrangements were in place to manage and administer people's medicines. Medicines were kept in a locked medicine cabinet secured in a locked office. Care staff were observed dispensing medicines to people. They took time with each person, asked for consent and ensured drinks were available to assist people to take their medicines. Medicine administration records (MAR) were signed after each medicine was successfully dispensed.

Robust recruitment procedures were in place. We reviewed five staff recruitment records and saw each staff member had completed an application form with a full employment history and had attended an interview to assess their suitability for the role. Each staff member had provided satisfactory references and photographic identity documents as well as completing a criminal records check which ensured only staff who were suitable to work with people in a care setting were employed.

People had individual emergency evacuation plans which guided staff in how to provide support and assistance to people in the event of an emergency evacuation. There were continuity plans in place to manage the home in the event of an emergency and for alternative accommodation if the home needed to be closed, for example, because of a flood or fire.

Requires Improvement

Is the service effective?

Our findings

Most people and their relatives felt their needs were met by staff who knew what they were doing. One relative said "Yes, well trained and knowledgeable." Another said they thought the staff were "Well trained." A care professional said of most staff "They know what they're doing" although went on to say some staff were better than others at identifying when people's needs had changed. A visiting GP told us they regularly visited the home and found the staff to be very good at calling them in for advice or treatment in a timely way.

Most people were supported with their healthcare needs, including receiving attention from GPs and district nurses, such as for pressure area care. A health professional told us the home responded when they made recommendations, such as to purchase a special bed to better support a person who needed to be cared for in bed. A trial period had been implemented for GPs to visit every Monday morning where people could book a session to discuss any health concerns. Senior care staff had received training to support people with basic health care. However, we observed that some people did not always receive appropriate treatment in a timely way. For example, we saw on 29 April that one person had an open wound on their hand which had a dressing on it. Records showed the wound had last been dressed on 19 April. The dressing was inappropriate as it did not completely cover the wound, and it needed changing as it was almost coming off. In addition, the person's hands were dirty and there was a build-up of dirt under their fingernails which increased the risk of infection to the wound.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014; Person centred care.

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. The registered manager and senior staff were knowledgeable about the requirements of The Mental Capacity Act 2005 (MCA), however, in some cases this had not been implemented correctly. Most people who required them had mental capacity assessments for specific decisions that needed to be made. Where best interest decisions had been made, these had been in discussion and agreement with relatives and other people involved in the person's care such as their GP.

Staff received training in the MCA however, this was not always effective. There was an inconsistent level of knowledge amongst care staff, some of whom did not understand the principles of the MCA and best interest decisions. We found inconsistencies in the implementation of the MCA and noted that one person, who had a care plan which stated they did not have capacity and their freedom was restricted to keep them safe, did not have a mental capacity assessment in place.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if

there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. There was an inconsistent knowledge of DoLS amongst the care staff team. However, the registered manager and deputy managers understood their responsibilities in relation to DoLS and had submitted relevant applications where required, although they were still awaiting a number of these to be assessed and authorised by the local authority.

New staff received a thorough induction when they started work and were required to complete an induction period and this included completing The Care Standards, a competency workbook to ensure new staff met the standards of care delivery expected. Areas covered in the induction included the values and philosophy of care in the home. Staff received on- going training and development in key areas such as moving and handling, first aid and fire safety, although some key areas of training were due for renewal. Each staff member was required to undergo regular competency assessments where they were observed by their line manager completing care tasks and any areas for improvement were recorded and discussed. This demonstrated that staff were supported to develop skills and knowledge necessary to support people in their care.

Staff received regular supervision with their line manager. This was a new system which included reviewing actions from the previous meeting, and raising areas of concern. For example, records showed that one member of staff had said they didn't know how to contact a manager out of hours, so this was discussed and recorded. One staff member told us that supervision gave them an opportunity to discuss the things they wanted to discuss, such as any concerns, training needs or ideas for improvements to the service. The provider had also implemented a new appraisal system which was due for completion throughout May, June and July.

Most people told us staff asked for consent before providing care and support, such as asking for their permission before administering medicines, and confirmed that staff respected their decisions. Throughout our inspection we saw that staff asked people before providing any support or care. For example, a staff member asked a person if they could help them put some antibacterial hand gel on their hands before lunch.

People were supported to eat and drink sufficient for their needs, although we received mixed comments from people about the food. Most people told us the food was good and they had some choice about what they had to eat and drink. One person told us "If I want bacon and eggs in the morning, I get it." However, some people told us the food was not always hot enough. One person said "The food is nice but it can sometimes be cold." Another person told us "The soup is cold." We observed the lunch meal on each day of the inspection in the dining room in the Engleburn unit. The main food item was brought to the table on the plate and staff served the vegetables from dishes at the table and asked each person what they would like and how much they wanted. One person was asked "Would you like gravy? All over?"

People who needed help to eat received assistance to eat their meal. For example, a staff member asked one person "Do you want me to cut it up for you?" The person responded with a yes and the staff member cut up the person's food and touched them affectionately on the shoulder when they had finished and said "Enjoy." However, not everyone enjoyed a positive mealtime experience. At lunchtime on 6 May we observed a member of staff in the lounge in Foxholes, physically feeding two people who were unable to feed themselves. They were sat on opposite sides of the lounge and the staff member walked back and forwards between them feeding each of them in turn. This did not promote a person centred mealtime experience for either person.

We spoke to the chef who was knowledgeable about people's dietary needs, their likes and dislikes and any

food allergies. For example, they told us who required a pureed or soft diet and how they prepared this. People who had been identified as losing weight had a fortified diet to help maintain or increase their weight. For example, the chef added butter or cheese to their food. People could also ask for snacks in between meals if they were hungry. Tea and coffee was brought around throughout the day and cold drinks were also available. This was important to prevent people becoming under nourished or dehydrated. People who were at risk of being under nourished or dehydrated had a food and fluid chart which staff monitored. Records showed people were offered, and consumed food and fluids at regular intervals throughout the day.

Requires Improvement

Is the service caring?

Our findings

Most people and relatives told us they thought that staff were caring. One relative said "Yes, they are all kind and caring. There is not one of them that isn't." One person told us "The staff are all very nice, very kind and caring." Another person commented that "The chef is exceptionally kind" and a third person told us "The girls [staff] are really nice to us." Another relative was enthusiastic about staff and said "[Our relative's] face lights up when certain carers come in to the room and she doesn't give us that reception!" People and their relatives said that people's privacy was respected and they were treated with dignity. For example, one person told us "They [staff] always knock on my door" before they entered their room.

However, we found that not all staff always treated people with respect and dignity. We observed on a number of occasions that some staff referred to people as their room number instead of their preferred name. During a conversation with a senior member of staff they talked about [room number]. Our inspector asked who that was as they didn't know who they were talking about and the staff member apologised and stated the person's name. We also observed that staff often referred to people who needed assistance to eat their meal as "Feeds." For example, at lunchtime on 29 April in Foxholes unit a member of staff asked a colleague "Is she the last feed?" A form on the wall in the Engleburn dining room for the allocation of staff at mealtimes referred to people as "'Challenging clients' and 'trays' and 'feeds'." This language was undignified and disrespectful towards people who had specific eating and drinking support needs.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Dignity and respect.

Staff, although busy, patiently supported people to maintain their independence as much as possible by offering reassurance and encouragement. One person had shown an interest in someone else's snacks so was encouraged by staff to purchase some snacks of their own from a vending machine. One person wanted to use the toilet and had started to unzip their trousers in a communal space. A staff member quickly and discretely responded "Pull your zip up darling. I'll take you to the toilet, just wait a second." A member of staff in Foxholes Unit spent time with a person who was agitated and refusing to eat. They engaged with them in a friendly way and reassured them they were doing well. Another person looked upset and sat with their head in their hands at the dining table. A staff member approached them and gently stroked their head and asked "Are you okay?" People responded positively to the kind attention and caring interaction.

Staff told us how they enjoyed supporting the people in their care. One staff member said they treated them like they would treat their own family and went on to say "I love my residents to bits." Another said of people they supported "They have had awesome experiences! I love listening to them" and went on to tell us about some of the life stories people had shared. It was evident that staff we spoke to respected people and their past experiences.

Staff offered compassion and reassurance to people who were nearing the end of their lives. Care pathways for the last days of life were in place and described to staff how people would like their last days and hours

to be, and guidance around who to contact. A relative told us how much they had valued the support of staff to help them during this difficult time. They said "They didn't just care about [my relative], they cared about me too. They were all so upset when [my relative] passed away."

People's bedrooms were personalised and reflected their preferences. For example, people had their own ornaments, pictures and photographs in their rooms. Relatives confirmed they could visit at any time and were welcomed by staff. Staff helped people to celebrate special anniversaries and birthdays. A relative had sent thanks for making a diamond wedding "such a special event for them and all the family."

Although no-one had a current need for advocacy support, the home had links with a local advocacy service which was available to support people if required which ensured they could contribute to making decisions about their care.

Requires Improvement

Is the service responsive?

Our findings

Most people and their relatives told us they were involved in or asked about how they would like to receive their care. A relative told us "I have seen [my relative's] care plan, in detail" although some people told us they did not know if they had a care plan. One person said "They do ask us about ourselves." One relative told us "I'm kept informed. They told me straight away if [my relative] was unwell." Another relative told us that staff had "Spent time with us all. We did a life history." They told us staff were very responsive and added, "Whatever we say, they go out of their way. They're on the phone straight away if [my relative] has a bump or a fall." A fourth relative said "They do look after [my relative]. They look after her like we would. They know her routine. "

People and their relatives were supported to be involved in the planning and review of their care. Most people, who were able to, confirmed they had been involved in discussions about their care and relatives told us they had also been consulted and informed of any health concerns. A staff member told us that care plans helped them to understand people, especially when they were quite new to the home.

However, we found a number of examples where people's care plans and risk assessments did not always reflect their current care needs so staff did not have up to date guidance in how to support people. For example, one person's circumstances had changed and their room was no longer locked for their safety. However, their care plan still stated that it should be locked. Where people lived with on-going pain this was not documented in their care plan to describe to staff how this pain presented itself, or how the pain was to be managed. The registered manager told us they would review the format of the care plans and include more detail, including pain assessments and pain risk assessments for people who required them.

Not everyone had regular access to social interaction and stimulation. We noted that people who chose to stay in their room, or who were cared for in bed did not have regular opportunities to participate in activities. We looked at people's activity records and saw that some people went for long periods without any activities. For example, one person who required one to one interaction had not had an opportunity to engage in any activities since 11 April 2016 and before this, since September 2015, they had gone for periods of two or three weeks without any activities being provided. We spoke with staff who told us there had been a period when activities staff had been covering a vacancy so the one to one activities had been missed. However, the dates we noted covered a wider time span of 8 months, more than the period of staff cover we were told about. We spoke to the registered manager about our concerns that people were at risk of social isolation.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person centred care.

Other people were offered opportunities to engage in activities in the communal areas. In Engleburn, people played skittles and quizzes and seemed to enjoy the interaction and banter. One person told us they did quizzes and used to play musical chairs. They said they had visits from a relative, but said the staff "Never take us out." In Foxholes Unit, it was more difficult to engage people due to their dementia. However, we

saw that group activities were planned, such as preparing fruit to eat, and those who wished to take part could do so. We saw minutes of residents meetings which showed people were involved in discussing what activities they would like, such as entertainers and themed days.

Each person had an initial assessment of their needs before moving into the home which included good detail of their life history, likes, dislikes and preferences of how they liked to receive their care. The assessments gave a good picture of each person, who they were and what they used to enjoy doing. We observed most staff responded to people's needs in a way that demonstrated they knew their likes, dislikes and preferences. The assessments informed the basis of people's care plans and risk assessments which were mostly detailed and covered specific areas of their care needs such as mobility, personal care and nutrition. One person had a very specific and complex mental health condition and we saw there were extensive risk assessments which paid particular attention to their behavioural and emotional needs. Their one to one support was well documented and appeared to be followed.

Staff completed daily records to show what care and support people had received. These included information about people's personal care, health concerns and mood. Staff attended handover meetings where important information about people was shared with staff coming onto their shift. This ensured all staff were made aware of people's current mood and state of health.

People and their relatives told us they knew how to make a complaint or raise a concern and who to talk to. Most people we spoke with told us they were satisfied with the home but would go to the office or speak to a senior carer if they weren't happy with something. One person told us "I have no complaints. None at all." A care professional told us "We've not had many complaints" about the home.

We reviewed the home's compliments and complaints records. Where complaints had been made, these had been investigated and responded to in a timely way. However, we noted some of the registered manager's responses to formal complaints were sometimes unhelpful and unprofessional. We discussed this with the registered manager who explained that some complaints were complex and were unable to be resolved to people's satisfaction. They told us they would seek additional advice from other stakeholders to try to reach an outcome that would be in the best interests of the people involved.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they thought the home was generally well run. One person said "You couldn't be in a better home." A relative told us "This is the best place in the area. They're so easy going." A relative told us "The manager pops in every now and then" however, other people told us they did not know who the manager was. A care professional told us "They are very responsive. It's a valuable resource in the area." A health professional told us the home communicated well and were "Quite on the ball."

The registered manager managed two homes that were run by the provider. We noted that they did not have an in depth knowledge of all aspects of the management of Engleburn Care Home, and during the inspection, often referred to the two deputy managers for information in order to answer a lot of our questions. They told us they were about to implement a re-structure of the management team. A new manager had been recruited and was due to start at the beginning of June 2016 and would manage the home with the support of the two deputy managers. The registered manager was going to become the area manager, and would line manage the new manager who would apply to register with the commission.

The deputy managers carried out audits to monitor the quality of the service provided. However, audits were not always effective in identifying issues, such as inaccuracies, omissions and discrepancies in record keeping which ensured people were receiving appropriate care. For example, one person, who had a current wound on their hand, had had a previous wound to the same hand which had been recorded in January 2016. However there was no record as to the origin of this wound, how it had been treated or when it had healed.

Another person had been admitted to hospital on 31 March 2016 for a health concern. The day before admission, staff had completed a body map and a description of bruises on the person's body. There was no reference to a pressure sore on their sacrum. The hospital completed a body map on discharge from hospital which identified a pressure sore, which they had treated and dressed, and additional bruising, which did not compare to the body map the home had completed the day before. We discussed this with the registered manager who seemed unclear about the hospital admission and relied on others to provide a verbal account of the pressure sore and bruising. They clarified that the person did not have a pressure sore and that the skin damage was 'normal' for the person, and this had been confirmed by the district nurse upon return to the home.

They showed us daily records completed by staff which were used to monitor the condition of the skin. However, it was clear that descriptions were subjective, with some staff describing the area as pink and others red, and there was no consistency in how they recorded what they saw so it would not be possible to effectively monitor the condition of the person's skin. The registered manager told us they had not noticed the inconsistency in the descriptions until they had checked, once we had brought the issue to their attention. They had not identified that staff did not have guidance about what was 'normal' for the person or what to look for that might indicate the skin was breaking down. They told us they would address this with staff.

There was insufficient monitoring and analysis of incidents, accidents and safeguarding concerns. Whilst individual records were kept, there was no overview of the numbers or types of incidents or safeguarding concerns to identify trends and themes in relation to these in order to learn lessons and reduce the risks of these happening again. A deputy manager created some templates during the inspection in order to start to record these but it was too soon to assess if these would be effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance.

The commission had not been notified of all incidents of abuse, as required by law. The registered manager confirmed they had not submitted notifications of all incidents of abuse between people living at Engleburn Care Home, such as verbal and physical abuse. They said they would do this in future but informed our inspector they would be inundated with notifications. Our inspector confirmed this was the appropriate course of action.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009; Notification of other incidents.

There were quality assurance systems in place to monitor people's satisfaction with the service. There was a list of dates for 'residents meetings' in the reception area so people knew when the meetings would take place in advance and could participate if they wanted to. Minutes from the February meeting referred to Foxholes needing some re-decoration and this had now been completed. People had chosen the wallpaper themselves. Complaints and compliments slips were available for people to complete. We sampled some of the comments and found they were mostly positive. For example, "Staff are always very pleasant and helpful" and They have made a sad situation easier" and "Cared for with dignity." Another comment suggested "More variety of biscuits." The kitchen had been informed of this so they could vary the range of biscuits from time to time.

The registered manager told us they were in the process of transferring people's care records to a new self-assessment system they had just put in place. This was a software package which enabled the management team to monitor how they were performing against the five key questions asked by the commission. Are they providing safe, effective, caring, responsive and well led care? It was too soon to assess how effective the system would be, but the management team were confident it would help to improve the quality of the service. The home also used the Gold Standard Framework as a template for supporting staff to deliver care. The Gold Standard Framework is an award which providers can work towards, and if achieved, helps them to demonstrate their excellence in care provision. Although they used it as a framework for good practice, the home had not signed up to achieve the award.

Most staff told us the home was well led, the culture in the home was open and managers were approachable. One staff member told us they felt some managers were more approachable than others, but would always find one of them in the office if they needed advice. Another staff member said "We have discussion in staff meetings and can raise concerns." Staff told us they felt supported and found staff meetings helpful. Senior staff met with managers every Monday morning to discuss what needed to be done and could raise any concerns regarding people's health or care needs. Other staff members said "I love it here, everything about it" and "We work well as a team. I am quite happy."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit notifications of all incidents of abuse as require by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provide had not always ensured they had done everything reasonable practicable to make sure people received person centred care that was appropriate and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider used language, verbally and in writing, that did not always have regard to people's dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always identified and assessed risks to people, and had therefore not mitigated such risks. The provider could not always demonstrate they had done everything reasonably practicable to provide safe care and treatment.

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 The provider did not have robust systems in place to protect people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance systems in place to monitor the safety and quality of the service. The provider had not maintain accurate, complete records in respect of each service user.