Interhaze Limited

# Wheatsheaf Court Care Home

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| 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 inspection took place over three days on the 18, 19 and 20 September 2017. The first day of the inspection was unannounced; we carried out an announced visit on the second day and completed the inspection with telephone calls to relatives of people who live at the service on the 20 September.

Wheatsheaf Court Care Home is registered to provide residential and nursing care for up to 55 older people, including people with dementia care needs. At the time of this inspection there were 31 people living in the home.
At the last inspection in September 2015, the service was rated Good. At this inspection we found the service to be rated Requires Improvement.

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

Improvements were required to ensure that people were kept safe in the home. Audits failed to identify that areas of the home accessible to people were not safe; risks posed by the on-going maintenance and refurbishment of the home had not been assessed. Some areas of the environment in which people lived and equipment they used was not always maintained to a sufficient standard of cleanliness.

Systems and processes in place to assess, monitor and improve the quality and safety of the service were not always effective at identifying concerns. Areas of the home were not well maintained and completed refurbishment had not been finished to a high standard. The improvements that were required to the home had not been planned or co-ordinated to ensure minimum disruption to people and the environment; there were on-going shortfalls as a result.

Where shortfalls were identified these were not always addressed in a sufficiently timely manner. People did not always receive their care from staff who knew them well as there was a high reliance on agency staff. As a result people could not be assured that their needs would consistently be met by staff who had appropriate knowledge and skills. Regular staff had received training that was relevant to their role, however at times the skills mix and experience of staff on duty was not sufficient to meet people's needs effectively.

The systems in place for responding to people's feedback required strengthening. People and staff had mixed views regarding how the service had responded to concerns and complaints. People were not consistently involved in planning their care and felt that there was not enough social stimulation and activity available.

Improvements were required to ensure people received their medicines as prescribed. The provider had

recently introduced an electronic medicine management system; whilst this was being embedded people could not be assured that they would receive their prescribed medicines safely.

People were supported and encouraged to eat well and maintain a balanced diet. People were supported to maintain good health; there was prompt access to healthcare services when needed.

Recruitment procedures protected people from receiving unsafe care from care staff that were unsuitable to work at the service. People felt safe in the home and received care and support from staff that had a good understanding of their responsibility to protect people from abuse and ill treatment.

There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005. Staff provided people with information to enable them to make informed decisions and encouraged people to make their own choices.

Regular staff were committed to the work they did and had good relationships with the people who lived in the home. People interacted in a relaxed way with staff, and enjoyed the time they spent with them.

Following the inspection, concerns were raised with us about the standard of care and support provided to some people. In response to these concerns a safeguarding referral has been raised with the local safeguarding authority; this is currently under investigation.

At this inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this 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 living in an environment that was not sufficiently maintained or clean.

People were not always protected from environmental risks as measures in place to identify and reduce these risks were not always sufficient.

There were sufficient numbers of staff on duty; however people's needs were not met by a consistent staff team. Lack of availability of permanent staff impacted on staff's ability to consistently meet people's needs.

There were systems in place to manage medicines in a safe way. However the recent introduction of a new medicines management system had resulted in errors in recording and administration.

People felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had access to regular supervision but this process had not enabled them to raise concerns they had regarding some aspects of the service.

People could not be assured that the knowledge and skills mix of staff deployed to meet their care needs was consistently effective.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and

Deprivation of Liberty Safeguards (DoLS).

People received the support they required to ensure that their nutritional needs were met.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

Regular staff had a good understanding of people's needs and preferences. However, the lack of availability of permanent staff resulted in people receiving care from staff who did not know them well. This impacted on people's experiences of personalised care and support.

There were positive interactions between people receiving care and support and staff.

People's privacy and dignity were protected and promoted.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

High reliance on agency staff impacted on the ability of staff to consistently support people with activities.

People were not routinely involved in planning and evaluating their care.

The systems in place for responding to people's feedback regarding concerns and complaints required strengthening.

People were assessed before they were admitted to the home to ensure that their needs could be met.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

People were not assured of a good quality service as there were insufficient systems and processes in place to effectively monitor the quality of people's care.

A registered manager was in post and they were supported by a care manager, who took responsibility for the day to day management of the home. However there was a lack of clarity amongst people and relatives regarding the leadership and management of the home.

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| Staff were aware of the vision and values of the service and worked hard to achieve these. | |

# Wheatsheaf Court Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over three days on the 18, 19 and 20 September 2017. The first day of the inspection was unannounced; we carried out an announced visit on the second day and completed the inspection with telephone calls to relatives of people who live at the service on the 20 September. The inspection was undertaken by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of co-ordinating care services for their relative.

Prior to the inspection the registered manager had 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. The provider returned the PIR and we took this into account when we made judgements in this report.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information sent to us by other agencies, including the local authority and clinical commissioning group, who commission services from the provider. We also contacted Healthwatch; an independent consumer champion for people who use health and social care services.

During this inspection we visited the home and spoke with eight people who lived there, six relatives and the pharmacist who supplies medicines to people who live in the home. We also looked at care records relating to four people. In total we spoke with thirteen members of staff, including the registered manager, care

manager and clinical lead, senior care staff, care staff and housekeeping and kitchen staff. We looked at four records in relation to staff recruitment, as well as records related to staff training and the quality monitoring of the service.

Requires Improvement

# Is the service safe?

## Our findings

People could not be assured that the environment they lived in was always safe. There were elements of the management of the environment and a lack of adherence to environmental safety measures that required improvement.

On the day of inspection we found that people who were living with dementia had access to rooms that contained items that posed a risk to their health and safety. The lock to the laundry room was broken and the door unsecured; this room contained chemicals and equipment. The door to the downstairs store room was not locked. This room was cluttered and contained many large items piled on top of one another. We also found bedrooms that were undergoing extensive refurbishment were accessible to anyone. One of these rooms had holes in the floor which could pose a risk to people. We brought this to the attention of the care manager who arranged for the doors in question to be secured.

On the second floor of the building two windows that should have had restricted opening due to the risk posed to people, were able to be fully opened; one window was wide open. Restrictors had been fitted to the windows but these had been partially removed to allow the frames to be measured for new windows and not replaced. This was discussed with the care manager who arranged for the restrictors to be re-fitted immediately.

Fire safety measures were not sufficient and the risks posed by the poor state of repair of some parts of the building had not been risk assessed. Holes in ceilings from previous leaks and poorly fitting fire doors posed a risk to fire safety. We found that two fire doors were being manually wedged open. There was no procedure in place for staff to ensure that these doors would close in the event of fire. These concerns were discussed with the registered manager who arranged for a full fire risk assessment of the building to be carried out. We also contacted the local fire authority to inform them of our concerns.

There were environmental risk assessments in place; however these had not identified the risks associated with the ongoing refurbishment of the building. There was a significant amount of refurbishment and maintenance work being undertaken in the home in areas accessed by people. No risk assessments had been carried out regarding this work and no plans were in place to mitigate the risks posed to people's health and safety. We found wires trailing across people's bedroom floors where a new nurse call system was being fitted. Pieces of wood with nails sticking out that posed a risk to people had been left on top of a radiator in a corridor after the old radiator cover had been removed. The provider requires a more robust system to mitigate the risks posed to people.

These concerns constitute a breach of regulation 12: Safe care and treatment (1) (2) (a) (b) (d) of the HSCA 2008 (Regulated Activities) Regulations 2014.

People were not supported to live in a well maintained environment. Water had leaked through the ceiling into a ground floor store room, resulting in wallpaper hanging from the ceiling and a smell of damp. There were other areas in the home where previous leaks had resulted in damage to the fabric of the building; on

the second floor there was a large hole in the ceiling of a corridor and bedroom that had been caused by a previous leak that had now been repaired. Scaffolding was in place and we were informed that work to repair the roof was ongoing. Some walls on the first floor were poorly maintained, with bare plaster and cracks exposed. The communal shower room in use on the first floor had tiles missing from the wall and cracked and poorly grouted tiles; in some ensuite bathrooms the wooden boxing around pipes was poorly maintained and coming away from the wall. Soap dispensers had been removed from several walls and the remaining holes in the walls had not been filled. We found several electrical installations that were without their covers, for example fuse boards and an emergency lighting fitting; we were told that these were no longer in use.

The home was undergoing extensive refurbishment; however the amount of work required had resulted in areas where the work had not been completed to a sufficiently high standard. New flooring that had been laid in people's ensuite bathrooms, bedrooms and corridors had not been laid or edged properly resulting in gaps between the flooring and skirting board; this made it difficult to clean. In one person's ensuite new tiles had been fitted around the sink but these had not had any sealant applied between the tiles and the sink. Two new lights that had been fitted in a corridor did not have the covers in place and the plug socket in a recently refurbished bedroom had a large gap around the outside.

People were not supported to live in a clean and hygienic environment and equipment provided for people to use was not sufficiently clean. The provider employed domestic staff, who were allocated to undertake cleaning duties within the home. However, the cleaning carried out by staff had not resulted in a clean, hygienic environment for people to live in. The skirting boards, walls and doors in many areas were poorly maintained and dirty. The wall behind people's chairs in the downstairs communal lounge where most people spent their day was stained and the skirting board was thick with dust. Bed rail bumpers that were being used to maintain some people's safety in bed were old, dirty and stained. There was a build-up of material in the Velcro designed to secure the bumpers that made it difficult to ensure they were adequately secured. This was discussed with the care manager during the inspection and they immediately arranged for the replacement of all bed rail bumpers.

The laundry process was not sufficient to ensure that people's clothing and bedding was cleaned to a sufficiently high standard. Three people's relatives told us that their family members bedding and clothing often returned from the laundry discoloured and stained. We saw sheets on people's beds that were marked and stained; these were made up ready for people to use.

We received additional concerns about the cleanliness of the service following our inspection and this information has been shared with the local authority and provider.

These concerns constitute a breach of regulation 15: Premises and equipment (1) (a) (e) (2) of the HSCA 2008 (Regulated Activities) Regulations 2014.

People could not always be assured that care staff were deployed effectively to meet their needs. There were sufficient numbers of care staff on duty, however high levels of agency staff impacted on people's experiences of the care and support provided. One person said, "There are lots of staff but not all regular staff; we do have agency." People were happy with the care and support provided by regular staff, but felt that the use of agency staff impacted on the quality of care they were received, as the agency staff did not know them well. One person said, "I think the ones who have been here some time, (not the agency staff you understand) are well trained." Three people's relatives commented on the high numbers of agency staff; one person's relative said, "It's hard for the regulars with agency staff because they don't know what they are doing and hold the regulars up – they have to explain to them all the time." Staff said that it was sometimes

difficult working with agency staff, depending on their previous experience working in the home. If agency staff had not worked in the home before it was difficult to meet people's care and support needs in a timely manner and staff had to rush. There was also a reliance on agency staff to cover qualified nursing shifts; to minimise the number of shifts that needed an agency nurse some permanent nursing staff were working a high number of shifts each week; this was not sustainable in the long term. The service was working with a recruitment provider to recruit sufficient nurses to cover all vacancies.

The provider had recognised that a lack of permanent staff impacted on the skills mix, experience and knowledge of the staff available and had taken some action to mitigate the impact. They had tried to ensure that regular agency staff were supplied to the home, carried out an induction with agency staff that had not been to the home before and ensured that they were allocated to work alongside permanent staff. A recruitment drive to recruit more permanent staff was on going.

People's medicines were not always safely managed. The provider had recently introduced an electronic medicines management system; the system was not fully functioning and this had resulted in a number of discrepancies. The first day of inspection coincided with the first day of a new medicines cycle and the clinical lead highlighted a number of concerns with the information provided by the medicines management system. For example, numbers of medicines recorded on the system and actual stock numbers did not tally. Also, some people's prescribed medicines were not on the electronic medication administration sheets (MAR). As a result one person did not receive their prescribed medicines; the provider raised a safeguarding referral with the local safeguarding authority regarding this. The care manager contacted the pharmacy who carried out a comprehensive audit of medicines records and stock on the second day of the inspection; all discrepancies were resolved. The provider needs to ensure that robust monitoring is in place as the system is embedded.

We observed staff administering medicines to people and we saw that they were patient, offered each person the support they needed and explained what the medicines were for. Staff followed guidelines for medicines that were only given at times when they were needed for example, Paracetamol for when people were in pain. The medicines policy covered receipt, storage, administration and disposal of medicines.

People's needs had been assessed and appropriate risk assessments were in place for people. These provided staff with the information they needed to support people in a safe way. Where people's support needs had increased, their risk assessment reflected their changing needs. People's care plans provided instruction to staff on how to mitigate people's risks to ensure people's continued safety. For example, the type of support people required to move.

When accidents had occurred, the registered manager and staff took appropriate action to ensure that people received appropriate and timely treatment. Training records demonstrated that staff had received first aid training. Accidents and incidents were regularly reviewed to establish if there were any incident trends and support plans devised to mitigate risks to people.

People were protected against the risks associated with the appointment of new staff. There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Records showed that staff had the appropriate checks and references in place and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

People were supported by staff that knew how to recognise when people were at risk of abuse and knew

what action they should take to keep people safe. One person said, "Yes, I do feel safe here; everyone is very good to me here." Staff were able to tell us about signs they looked out for which may suggest somebody was at risk of harm and the action they would take.

Following the inspection, concerns were raised with us about the standard of care and support provided to some people. In response to these concerns a safeguarding referral has been raised with the local safeguarding authority; this is currently under investigation.

Requires Improvement

# Is the service effective?

## Our findings

Staff had access to regular support and supervision; however this process had not been effective in enabling staff to raise the concerns that they had regarding staffing and the environment. Staff told us that they were concerned about the deployment of staff and maintenance and cleanliness of the home, but did not have confidence that these concerns were being addressed. They had raised some concerns with senior staff but were not clear what action had been taken to address their concerns. Supervision meetings were used to assess staff performance and identify on-going support and training needs, however staff did not find these effective in addressing their concerns and to support them to carry out their roles and responsibilities.

People could not be assured that their needs would consistently be met by staff who had appropriate knowledge and skills. Regular staff had received training that was relevant to their role, however high agency usage meant that at times the skills mix and experience of staff on duty was not sufficient to meet people's needs effectively. Records showed that regular staff had accessed training in key areas such as dementia awareness and food hygiene on a regular basis. Additional training, relevant to people's needs included training to support people with their behaviour. Nursing staff were supported to access training appropriate to their role including catheterisation, emergency first aid and pressure ulcer and wound care training.

New staff received an induction which included practical training in areas such as manual handling and shadowing experienced members of the staff team. Staff did not work with people on their own until they had completed the provider's mandatory training and they felt confident to undertake the role. Newly recruited staff also undertook the Care Certificate; this is based on 15 standards that provide staff with the introductory skills, knowledge and behaviours to provide quality care and support. One member of staff said, "The training was quite good, I worked for a week and a half with another carer before I was allowed to work on my own with people, I also did the Care Certificate."

People received care and support from staff who understood how to ensure that support provided was in people's best interest. Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and applied this knowledge appropriately. The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff were aware of their responsibilities under the MCA and DoLS codes of practice. Care plans contained assessments of people's capacity to make decisions and recorded when 'best interest' decisions had been made. The provider had followed the legal process when applying for DoLS authorisations to place restrictions on people's freedom. Appropriate plans of care were in place to ensure that people's care and support needs were met in the least restrictive way and we observed that staff

asked for people's consent before providing care.

People had access to health care support when they needed it and staff were prompt to call the GP for acute health problems. One person said, "I needed to see the doctor for a chesty cough, they took me straight away to the surgery and I got some tablets." People were also supported to access support from a range of healthcare professionals such as community psychiatric services, optician and dentist. One person said, "I couldn't eat my toast; the hospital lost my teeth so they have sorted out a dentist for me to go to and get me some new teeth. I went there today and I should get them next week. They are very good at keeping you well here."

Staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietician when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people
were able to have adequate food and drink safely, for example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed. People's care plans contained detailed instructions about people's individual dietary needs, including managing diabetes and food allergies.

People received the support that they needed to eat and drink enough to help maintain their health and well-being. We observed lunch being served; people were provided with a choice of meal and an alternative if they did not like what was on the menu. The majority of people said that they enjoyed the food; one person said, "I am satisfied with the food, generally it's okay."

Requires Improvement

# Is the service caring?

## Our findings

People's experience of care was different depending on the numbers of permanent staff on duty. People and their relatives were consistently positive regarding the way in which permanent staff engaged with them and provided their support. However, when high numbers of agency staff were deployed this impacted on the ability of staff to provide personalised care that focussed on supporting people's choices and well-being. Three people's relatives spoke about the impact of the lack of permanent staff. One person's relative said, "The regular staff know them well and chat to them about their past but the agency staff can't do this. Also, when there are a lot of agency they don't have time to chat to the residents." Another person's relative said, "The permanent staff are brilliant, but there's not enough of them." Staff told us that it was more difficult to provide personalised support when they worked with agency staff who did not know people as providing people's personal care took longer.

Improvements were required to the environment to support people's well being and independence. The service supports people living with dementia; however the environment had not been designed or decorated to support people to find their way or feel comfortable in their surroundings. Some corridors that people needed to move through to access different areas of the home were not decorated, well maintained or welcoming. There was very little signage or pictorial information to support people to orientate themselves or provide people with information. A menu board was displayed in the dining room, but this displayed details of a meal that had been served in August.

People's belongings were not always treated with respect. We observed that people's clean clothes were not stored in a way that maintained them in an appropriate condition for people to wear. Wardrobes contained clothes that were very creased as a result of being screwed up on the floor of the wardrobe. One person had limited space to store their clothes as a pressure mattress was wedged at the bottom of their wardrobe. The care manager confirmed that there was no reason for the mattress to be stored here.

Staff supported people in a kind and caring way and had built positive relationships with people and their families. One person said, "I can't fault the regular staff, they can't do enough for you, they are very helpful. I need them to help me get washed and dressed, they are very kind." Another person said, "Kind, good girls, thankyou." Another person's relative said, "The staff are lovely, they have supported both of us wonderfully, they are caring towards us both."

We observed staff having meaningful conversations with people and it was clear that permanent staff knew people well. People's individuality was respected by staff and we observed staff gently encouraging people to make choices and do things for themselves. One member of staff said, "Everything is an experience; I always make time to talk to people and try to encourage them to do what they can for themselves. For example if they're having a wash encourage them to wash their face."

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information without people's consent. People's right to privacy was protected by staff. One person said, "They get me washed and dressed and they respect my space, you know my privacy." Staff were

mindful and considerate of people's wishes when asking if they could enter their rooms. We observed staff knocked on people's bedroom doors and waiting to be invited in before entering the room.

The provider supported people to speak up for themselves and were aware that if people did not feel able to or had no family to support them that they would support them to find an advocate. At the time of the inspection two people were being supported by advocacy services.

Requires Improvement

# Is the service responsive?

## Our findings

The system in place to allow people and their representatives to contribute to their care plans and risk assessments was not effective and people were not consistently consulted about their care. People and relatives that we spoke with said that they were not aware of the information contained in their care plan and they did not know how their care needs were evaluated and reviewed. The registered manager told us that people's care plans should be discussed with them and that they should be invited to a review every three months. However this had not been happening in practice and at the time of inspection people and their relatives were not consistently invited to reviews of their care needs. Therefore, people did not have the opportunity to make their wishes and views known regarding how they wanted to be supported; there was a risk that people would not receive support as they chose.

Staff did their best to engage people in activities but people told us that the lack of staff impacted on the activities available and there were not enough varied things to do. One person said, "We don't have enough to do here, we just sit and watch the television, it can be a very long day." Another person's relative said, "There's been no entertainment manager for about three months so there's not enough stimulation." A member of care staff had been re-deployed to support activity provision but we were told us they were sometimes moved from activities to support with care provision. They were passionate about providing people with appropriate social stimulation and activity and told us, "I try to make an activity out of all experiences. For example the dining experience; we fold napkins together, have music in the background, and talk about people's life, what they did and what they enjoyed." We observed activities taking place on both days of the inspection including reminiscence, skittles and a 'sing-a-long'.

Arrangements in place for managing complaints required strengthening. Feedback from people and their relatives and staff regarding the provider's response to complaints was mixed. Staff told us that they had reported concerns regarding the high use of agency staff and laundry service to senior staff, but were not sure what action had been taken to respond to these concerns. People and their relatives told us that they knew who to speak to if they were unhappy with any aspect of the service. During the inspection we observed one person's relative came to the office to raise a concern with the care manager, who took prompt action to resolve this.

We saw the provider had developed a formal complaints procedure that should have ensured good complaints management. A complaints log was in place, we saw records that detailed concerns raised and the action taken by the manager in response to these concerns. However, we found that when people provided staff with negative feedback there had not always been recognition that they may wish to have these issues investigated. Two people's relatives told us that they had expressed concerns to staff about aspects of the service, they did not feel any action had been taken in response to these concerns.

People's care and support needs were assessed before they came to live at Wheatsheaf Court Care Home, to determine if the service could meet their needs. The assessment considered people's past and current needs and the information from the assessment was shared with staff. Initial care plans were produced and these were monitored and updated as necessary.

Permanent staff knew people well and had an in-depth understanding of their care and support needs. People said that they were happy with how they provided their care and support; one person said, "Well the regulars know me and know how I like things. I have no complaints about them."
There were good verbal communication systems in place to support staff; we observed staff handover taking place and the information provided to staff at the beginning of their shift ensured that they were aware of any changes in people's care or support needs. Relatives were contacted promptly if staff had concerns about the wellbeing of the person.

People chose how and where to spend their time. Meals were served in either people's own rooms or in the lounge and dining area. Some people liked to spend time in their bedrooms; others spent time in the communal areas.

The provider had recently introduced an electronic care planning system and staff were in the process of uploading people's care plans and assessments to this system. Care documentation was person centred and gave good descriptions of how people should be supported. Staff were provided with clear information regarding how they should respond to people in particular situations. For example where people required support with personal care, their care plans provided staff with clear guidance on how to do this. Where people were at risk of pressure ulcers, their care plans recorded the equipment and support they required to help prevent them.

Requires Improvement

# Is the service well-led?

## Our findings

There was insufficient monitoring of the quality and safety of the service. The registered manager told us that the provider visited the service regularly but did not complete any formal quality monitoring or audits of the service. As a result there was a lack of evidence of provider oversight of the quality and safety of the service experienced by people living in the home. Where audits had been completed, they had failed to identify the issues we identified during this inspection.

A range of audits had been completed; however, some of these audits were not effective at identifying or addressing shortfalls. Regular environmental audits had been completed; but they had failed to identify the environmental safety concerns found during this inspection. This meant that people continued to be exposed to risks associated with chemicals or substances hazardous to health and had access to areas of the home that were potentially dangerous.

There was insufficient oversight of the maintenance of the building and improvements were required to maintain the environment to a sufficient standard. There was no plan in place to schedule how the required environmental improvements would be undertaken. The registered manager was not able to provide us with an overview or plan of the on-going maintenance programme, or demonstrate how this would be achieved with minimum impact on the people who were living in the home. Many areas where refurbishment work had begun were only partly completed as other maintenance work had been prioritised as more urgent. There was no system in place to ensure that maintenance work completed was of a sufficient standard. This resulted in the concerns identified during this inspection in rooms where refurbishment and decoration was considered to have been completed.

The management team had not ensured that the environment and equipment used by people were sufficiently clean. The cleaning programme in place was not sufficient to ensure that a sufficient standard of cleanliness was consistently maintained. This included on a day to day level, but also on a longer term basis where it was clear that dust and dirt had built up over time. There was also a lack of action regarding the ineffective laundering of people's clothes and bedding. The processes in place failed to ensure that people's clothes and bedding were sufficiently clean when they were returned to them. The systems in place had failed to adequately review and monitor standards of cleanliness.

Quality assurance processes were not consistently effective at ensuring the actions required to implement improvements were taken in a timely way. The provider was aware that staffing deployment was not always meeting people's needs. There had not been a timely response by the provider to ensure that a consistent staff team, who knew people well were deployed to provide people's support. This had impacted on people's experiences of care and access to social stimulation and activity. The care manager was aware that people and their relatives were no longer being consistently involved in discussions and reviews of their care needs. Insufficient action had been taken to ensure that people were informed of the opportunity to discuss how their care would be provided.

These concerns constitute a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014, Good Governance.

Staff understood the management structure, but were not confident that their concerns would be addressed. One member of staff said, "We do raise our concerns but we don't really know what is done in response." Some people and their relatives felt that there was a lack of clarity regarding the management and leadership of the home. The care manager had responsibility for the day to day management of the home as the registered manager was not based in the home on a daily basis. Some people and relatives were unclear who was responsible for the management and leadership of the home; they told us that they relied on care staff to keep them informed of any changes.

The provider had a process in place to gather feedback from people, their relatives and staff through surveys and meetings. We saw minutes of a recent residents and relatives meeting; feedback from relatives was positive about this meeting although they said they would like them to be held more often. During staff meetings, staff had the opportunity to discuss people's care needs and any new equipment that was required to support people. We saw meeting minutes which recorded discussions about documentation, staff duties and the purchase of new pressure relieving equipment.

Policies and procedures were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies such as safeguarding and whistleblowing. The registered manager had a good understanding of what notifications the Care Quality Commission required and sent these promptly when necessary.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider had not ensured that the environment in which people lived was safe. 12 (1) (2) (a) (b) (d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment |
| Treatment of disease, disorder or injury | The provider had not ensured that the environment was well maintained and clean. 15 (1) (a) (e) (2). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider did not have sufficient arrangements in place to monitor the quality and safety of the care and support provided in the home. 17 (1) (2) (a) (b) |