Bellhouse Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 7 June 2018 and was or unannounced. The service had previously been inspected on 25 January 2017 and was in breach of the regulation in safe care and treatment. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the service to at least good. This inspection showed insufficient improvement had been made and this is the third consecutive time the service has been rated Requires Improvement.

Bell House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 24 people in one building. There were 15 people living there permanently at the time of the inspection and a further four were staying there on a temporary basis.

There was no registered manager in place. The previous registered manager had left the service in June 2017 and a new manager had been appointed in November 2017 and had applied to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines management was safe and we observed medicines were administered appropriately during our inspection.

Risk assessment and risk management plans had been an issue at our last inspection. We found in some areas this had improved, but at this inspection, we found some areas of risk had not been considered. This put people at risk as it meant staff had not minimised harm to the person.

People living at the home and some of their relatives told us there were times when staffing levels were insufficient. This meant people did not always get an immediate response when they asked for support. Staff told us certain times of the day were busy and they acknowledged a recent increase in new people at the home had affected the time they had to support people.

We found all the areas of the home we inspected were clean which ensured the risk of infection was minimised. The registered provider continued to upgrade the environment internally, with new carpets, doors and decoration of the home.

We found some decision specific capacity assessments had been carried out for people, which were compliant with the Mental Capacity Act 2005 (MCA). However, not everyone who needed a capacity assessment had this in place and not all best interest meetings had taken place to ensure the home was

meeting the requirement of the MCA Code of Practice.

People had been referred to other health professionals when the need arose and we saw this had positively affected people's wellbeing. We received positive feedback about the service from a visiting health professional. However, we also found occasions when professional advice had not been sought promptly.

We observed staff were very kind and caring when they were supporting people with care. People at the home and their relatives told us how kind and helpful some members of staff were and how they treated people with dignity and respect. However, following the inspection we were advised of a situation where people had not been supported with dignity.

Some records contained person centred information detailing people's life histories, preferences and choices. However, other records lacked detail and were incomplete in this area. We found care plans did not always evidence people's current care needs.

We found there had been a lack of strong leadership at the home. Not every area of care had been audited in enough detail to determine the quality of the service provided. Where audits had been completed and actions identified, it was not always clear improvements had been sustained as we found similar issues recurring.

Some areas of quality monitoring were effective such as environmental checks and improvements to the environment. The registered provider utilised external companies to maintain equipment and for their servicing arrangements. However, there had been a lack of overall assessment and monitoring of the quality of the service provided to people. The systems and processes were not robust enough to ensure full compliance with the regulations.

We found the service was in breach of several regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

There was not always adequate staff at the home to ensure people's needs were responded to promptly and there was no robust audit of staffing levels.

Risks were not always appropriately assessed to ensure people were protected from harm.

We found medicines were stored and administered safely and we observed medicines being given appropriately

Is the service effective?

Requires Improvement

The service was not always effective

The manager had not ensured every person's nutritional and hydration needs had been assessed and met.

The home was not yet fully adhering to the principles of the Mental Capacity Act.

We saw evidence staff had appropriately referred to other health professionals when the need arose. However, on occasion advice had not been sought promptly.

Is the service caring?

Requires Improvement

The service was not always caring

We observed staff to be caring and compassionate during our inspection.

Feedback received indicated low staffing levels had impacted on staff ability to provide dignified care.

People's rights to confidentiality was respected

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always up to date to include people's actual needs.

Not every person had a record of their life history in their care plan to enable the provider to tailor care to their preference.

There was a plan of organised activities but outside of these times, there was little evidence people were provided with purposeful and meaningful activities throughout each day.

Is the service well-led?

Inadequate

The service was not always well-led.

There was a lack of leadership at the home to drive improvements required. Quality assurance and governance systems had not identified current performance accurately to enable the provider to improve.

The provider was not measuring the service against current guidance.

All audits in relation to the environment were accurate and up to date.

Bell House Care Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 7 June 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and an inspection manager.

Prior to the inspection, we reviewed all the information we had about the service including statutory notifications and other intelligence. We contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire service, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

The registered provided 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.

We spoke with five people living at Bell House and two relatives. We spoke with a further two relatives after our inspection. We spoke with the registered provider, the manager, two senior care assistants, one care assistants and the chef during our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We observed the lunchtime meal experience in the communal dining area and observed care

interventions throughout the inspection process. We reviewed five care files and daily records of people who had received care and support at the home. We also reviewed the maintenance and audit records for the home and records relating to staff and their training and development.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we found improvements were required in the assessment and recording of some risks and there was not always detailed guidance for staff to follow. At this inspection although some improvements had been made, we found not everyone who required a risk assessment and associated risk reduction plan had these in place. The manager told us what they had done to mitigate the risks, but there were no records to confirm this. For example, two people whose behaviours had challenged others did not have behaviour management plans in place.

The home completed risk assessments for other risks such as choking, medication and moving and handling. We found standardised risk assessments to assess the risk of a person developing a pressure ulcer and the risk of malnutrition were in place in most care files. We found a person at risk of malnutrition had not been weighed regularly and their weight recorded in their care file to enable a specific care plan to be put in place. This meant their significant weight loss had not been acted on promptly. Another person who had issues with their bowels had medicines in place to use when required but their records showed this had not been given. We were concerned about the lack of oversight in relation to these risks, which showed the systems the home had in place were not sufficiently robust. Another person was using a type of hoist, which staff and relatives considered no longer met their needs. However no contingency arrangements had been put in place whilst they awaited a reassessment. This meant the provider had not appropriately managed the risks of harm in these situations.

We asked the registered manager how they investigated accidents and incidents to learn lessons and make improvements to people's safety. They said staff completed an accident form after each incident, and they as the manager looked at these to determine what happened and why. They told us it was usually "falls and skin tears" and staff discussed falls at handover to reinforce the need to constantly remind people to use their walking aides. We reviewed the accident and incidents and noted one person had several falls. When we reviewed their care plan there was no falls risk assessment in place. We discussed this person with a member of staff and they were able to tell us the measures they had put in place to help minimise this person's fall, but this was not reflected in a falls risk assessment and care plan.

Fire alarms were tested regularly and equipment such as extinguishers were checked by an external contractor. At our last inspection we found an improvement in people's personal evacuation plans (PEEPS) to guide staff how to support individual people in the event of an emergency. These were not in place at this inspection and when we raised it with the manager, they were aware of this and it was on their list of actions to complete but this had not been given a priority. No simulated evacuation had taken place and it was not clear that enough thought had been put into considering how they would evacuate all the people at the home in the event of a fire. We discussed this with the manager who told us they would be initiating simulations in the near future. They told us they intended to compile a grab bag for emergencies such as a fire or ambulance service to ensure information about people is at hand. The signing in and out book for visitors was not in chronological order and had pages added randomly. We raised this with the manager who agreed to ensure every person who visited the home signed in and out. We also contacted the fire service in relation to our concerns.

These examples demonstrated a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

People told us they felt safe at the home. One person said, "I feel safe. I have never witnessed anyone being treated badly here. The staff are good." However, when we asked people how long they needed to wait when they required assistance, people told us they often had to wait for the care staff to support them. One person said, "You never have to wait a long time, but if staff are supporting someone else, you have to wait. Sometimes it might be 15 minutes in the day." Another person told us they had on occasion waited up to one hour to be supported.

We reviewed the staff rota, dependency tool and spoke with people living at the home and their relatives to check there were sufficient staff to provide a safe service. The dependency tool in use by the registered provider outlined a framework for determining the amount of hours required for people based on their individual needs. The manager and registered provider discussed staffing levels on a weekly basis. We had concerns about staffing levels at the home as staff provided support with domestic tasks in addition to care tasks and supporting holistic aspects of care such as people's mental wellbeing.

There were times during our inspection when there were no staff in the communal areas, so we asked staff how people summoned assistance at these times. Call bells were fitted to the walls, which meant not everyone could get to them. One member of staff told us, a more able person would get up and ring the pull cord for assistance, if a less able person required assistance. Two of the relatives we spoke with told us they had concerns staff were often in the dining area (writing notes) rather than with their relations in the communal lounges. This arrangement posed a risk to people's needs being met promptly and put the onus on other people at the home to provide a response.

There were two shift patterns, the early shift from 8am to 8pm and the night shift from 8 pm to 8 am. Three staff plus the manager supported the early shift and two staff supported the night shift. As there were several people who required the support of two staff to care for them, this meant if people chose to go to bed after 8pm or get up before 8 am there were no staff available to support other people requiring assistance. Staff told us there were occasions when only two staff were available to support people during the day. Our review of the staff rota showed how many staff were due to attend each shift but not how many staff had actually completed each shift. The rota showed three staff on at most times but we noted that on several occasions only two staff had been on the rota. This meant it was possible there were periods where no care staff were available to support people as they were busy supporting people who required two people to assist.

We discussed staffing levels with the manager and registered provider who told us they had already decided to add an extra carer in the morning starting at 6 am. However, they were unable to demonstrate there had been a real analysis of people's needs considering factors such as people's behaviours and a recent intake of new people at the home, which could have an impact on staffing.

These factors demonstrated there was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were not confident there were enough staff to support people at the home with a timely response to their need for care.

We asked staff about their understanding of safeguarding. They demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. There were posters in the building to direct people to a telephone number to contact if they had information and they wanted to 'whistleblow.' A whistle blower is someone who reports concerns about

unsafe or illegal practices in the work place.

Staff files contained the appropriate checks including Disclosure and Barring Checks. The Disclosure and Barring Service (DBS) helps an employer make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. References were checked and verified and any gaps in employment reviewed.

We looked to see how the service was managing people's medicines including the ordering, storing, administering and disposal of medicines. Medicines were safely administered and securely stored; the systems in place to manage this were effective, although there were some minor areas which required improving. For example, the temperature in the medicines room had been recorded as below the acceptable temperature range for a number of days without any action.

We observed the home was clean and staff had access to plentiful supplies of protective aprons and gloves. The home employed a housekeeper between 9am and 1 pm. Care staff undertook cleaning duties outside these hours. Some carpets had been recently replaced and the programme of refurbishment was on-going which gave the home a refreshed appearance.

Requires Improvement

Is the service effective?

Our findings

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.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were three DoLS authorisations in place on the day of inspection and we checked these to ensure conditions of authorisation had been met. Further applications has been made which meant the provider understood their responsibilities in relation to deprivation of liberty safeguards. .

Mental capacity assessments ensure the rights of people who lacked the mental capacity to make decisions were respected. The manager had a good understanding of the MCA, although had not applied it to everyone at the home. Not everyone had decision specific capacity assessments in place and the manager told us they had not yet held any best interest meetings with families since they had been at the home.

The provider used two stage capacity assessments to determine if people had capacity to make a decision. Several care plans had undated mental capacity assessments in place. One of the care plans we looked at contained decision specific mental capacity assessments and included one in relation to a decision about medicines. However, another did not have this in place. Two people on short-term respite placements did not have mental capacity assessments in place in relation to their stay or the care they would receive whilst at the home. We raised this as an issue with the manager who agreed to act upon it. Our discussions with staff found some staff had a good knowledge whilst other staff would benefit from further training, as although they could describe how they acted in people's best interests they were unsure of the legal process, which meant they might not always apply this in day-to-day practice. For example, one person who had been assessed as lacking capacity had also signed their care plan consenting to their care delivery

The lack of evidence of lawful consent demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime dining experiences in the communal dining room. We found the experience was relaxed with the tables set out nicely with tablecloths and condiments and music playing in the background. We saw jugs of water and fruit juice in the communal areas and people were offered these during the day in addition to tea and coffee.

People told us how much they enjoyed their lunch and we received the following comment, "Lovely." One person told us, "Nice cooked dinner, but tea time is just sandwiches or beans on toast, sometimes just a

cake." Staff told us they would prepare an alternative if people wanted this and one relative told us their relation, "asks for different food and gets it when she requests it."

The home employed a chef to cater for people's breakfast and lunch. They finished at 1.30 pm and prepared a light snack for people's evening meal. They had a good knowledge of people's nutritional requirements including who required a low sugar diet and who required fortified food to increase the calorific content. The manager told us menus followed a four-week rolling programme following discussions with people living there. People told us the quality of the food at lunchtime was very high and we could see it had been prepared using fresh ingredients. However, people and some of their relatives told us they did not think teatime was adequately nutritious or substantial. This also affected staff availability as they prepared the teatime snack for people, which meant they were not available to provide care if this was required.

The manager advised us two people required a fortified diet and both had been referred to a dietician. In one person's file we saw clear guidance from a speech and language therapist, which had not been transcribed into a nutritional care plan. There was a lack of prompt action when they were declining to eat and drink which demonstrated for this person the home could not evidence they had managed this aspect of the person's care needs well. This demonstrated a breach in Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people at the home whether staff had the knowledge and skills to care for them. One person said, "The staff are brilliant. They know what they are doing."

New staff were supported to develop into their roles through induction, supervision and training. One new member of staff told us they had shadowed four shifts before being placed on the rota. They described training they had received as "Good" and it had provided them with the knowledge to support people. They told us they had been supervised twice since taking up their post and they felt supported by the manager and the staff team. The manager told us they were not currently undertaking the Care Certificate (The agreed set of standards that sets out the knowledge, skills and behaviours for care workers) but they had plans in place to start this for new staff and to use the self-assessment tool for current staff to use to identify where they needed to refresh their knowledge.

The manager had undertaken a training audit when they had taken up their post and monitored staff training on a regular basis. They kept a matrix to enable them to have an overview of staff training and sent us their training matrix following the inspection. The manager told us some training was face to face such as moving and handling and other training was done on line. We saw staff had been trained and their competence checked around moving and handling people safely and in the management of medicines.

Staff were supported to do the online training at work, as the manager told us not everyone had access to a computer at home. We asked about specialist training, and how they could access this. The manager told us if a person came in with a new need, they would speak to the registered provider to see if they could access training. Staff knowledge on how to manage people whose behaviours challenged had not been refreshed and was very basic. Training had been planned, but although there had been an issue with managing people with behaviours that challenged, this had not been prioritised.

We saw people using the service had access to other health care professionals for example, GPs, district nurses, chiropody, dentist and optician. Community psychiatric services had also been involved with positive outcomes for people at the home. We also met a community nurse who was very complimentary about the home and the appropriateness of referrals to their service. However, we also found in two people's records they had not looked holistically at their physical and mental health needs in order to seek

the necessary assistance.

The registered provider continued to upgrade the environment internally, with new carpets, doors and decoration to one wing of the home. They were considering options to alter the communal dining area to make additional space for people to sit. There was limited space in the communal lounge as it was currently laid out for people using assistive equipment. One person liked to sit outside but told us they were dependent on asking staff to support them, as there was no direct access outside to an enclosed garden area where people could wander in and out freely.

Requires Improvement

Is the service caring?

Our findings

We observed staff were very kind and caring when they were supporting people with care. People at the home and their relatives told us how kind and helpful some members of staff were and how they treated people with dignity and respect. One person, whose appearance was important to them told us, "The hairdresser comes every week. I like having my hair done." Their relative said, "Clothes are always clean, but sometimes not ironed." Most people were well dressed and it was clear they took pride in their appearance and were supported by staff to maintain their appearance. We observed one person with dirty fingernails, wearing a top with a stain on it, which we raised with the management team to ensure their dignity was also respected. We received feedback following the inspection which indicated low staffing levels had impacted on staff ability to provide dignified care, particularly supporting people to access the bathroom.

The manager told us they ensured staff provided person centred care by observing staff to see they were treating people with dignity and respect and offering people choices in their everyday lives. Staff spoke about the importance of ensuring privacy and dignity was respected, telling us how they ensured this when providing care. One said, "we ask what they want to wear and have a chat whilst getting dressed. We let them choose what they want to wear."

We saw staff ensuring people's privacy was respected when visiting professionals came to the home. For example, one person was sensitively supported to their bedroom when the chiropodist arrived and another when the community nurse attended to their needs. This meant their privacy was assured at these times. However, we saw some recording in a person's daily record, which was not person centred, and at times, we heard people referenced by their room number and not by their name. When we approached staff about this, they said they had been told to do this by a previous manager to ensure confidentiality. We raised this with the registered provider, as this type of reference does not reflect respectful, person-centred care.

The manager told us people were involved in writing their care plans and if they could not provide the information, they would speak with their family. Our discussion with people showed people were not fully aware of their care plans, as when we asked people if they had been involved in writing their plans they told us they were not aware they had care plans. The level of personalised detail in care plans was variable, indicating that although some people had been involved in the care planning process, this might not always have taken place. We mentioned this to the manager and registered provider, who told us people had been involved in writing their care plans but they would ensure they clarified this with people.

We saw reference in people's care plans how best to communicate with them to ensure they were fully involved in their care on a daily basis. This meant staff had the information required to guide them to communicate with people whilst providing their care.

People were supported with their religious and spiritual needs and these were recorded in their care plans. One person told us, "We have a female chaplain that comes and I enjoy seeing her once a month." Staff told us how they themselves were supported to practice their religion and other staff who recognised the importance of supporting colleagues from diverse backgrounds to practice their faith corroborated this.

People were also encouraged to retain their independence and care plans recorded what people were able to do for themselves. The service accessed advocates when required. An advocate is a person who is able to speak on another person's behalf when they may not be able to, or may need assistance in doing so for themselves

Requires Improvement

Is the service responsive?

Our findings

Pre-admission assessments had been completed and information had been gathered from the person, their family and in some cases from hospital staff. This information is essential to ensure the home could meet the needs of the people coming to live at the home.

The manager told us since taking up post they recognised some care plans were generic and staff were adding to care plans rather than updating them when people's needs had changed. They said they were reviewing care plans to ensure they were more person-centred and the updates would happen at the person's review or as and when people's needs changed.

Staff told us they had recently had a number of new people at the home, some on a temporary and some on a permanent basis. One member of staff said, "It's hard work with respite getting care plans together." We found the registered provider had not increased staffing levels during this time to allow staff to write high quality plans for all the people living at the home whether on short or longer-term basis.

Some of the information in care files contained people's life histories to tailor care to meet the person's needs based on past life experiences, preferences and previous choices. Others did not contain this information and the manager told us they had plans in place to rectify this, and this information would be gathered at people's reviews.

People's end of life wishes were recorded in their care plans including their funeral arrangements. Where people had not made or did not wish to make the decision at the time, this was also recorded and reviewed. No one was receiving end of life care at the time of the inspection. There were people who had anticipatory medication in place as they had palliative care needs.

The manager told us they had assessed a few people recently whose behaviour challenged others but this had not been apparent at the preadmission assessment. There was no information in the care plans we reviewed to demonstrate they had considered triggers for behaviours that challenged, and the lack of plans in place meant the provider could not demonstrate they had provided responsive care.

We checked with staff how they anticipated people's needs particularly for those people who might not recognise they need support. One member of staff said, "There is a buzzer on the wall in the communal lounge. They will ask someone else to call the buzzer for them." When we queried that this might be the case for everyone, they said, "Most people will ask. I don't think there is anybody who wouldn't ask." We asked whether consideration was given for updating the call bell system so people could summon assistance without the need to go through the more able people, and we were told this had been discussed.

One person told us they would like to have a bath but had only been offered a shower. When we discussed this with the manager, they could not evidence if the person had a bath or a shower as this had been taken off the personal hygiene record sheet. We found gaps in records to detail the actions taken when a person had identified significant weight loss. Another record did not detail what actions had been taken around a

person's bowel management. Records around people's behaviour management to show how staff were to address these issues to reduce risks had also not been completed. Although the manager assured us actions had been taken, the records did not corroborate this, which was of great concern.

The lack of accurate and contemporaneous records demonstrated a breach in Regulation 17 of the Health and Social Care Act

We asked people about the activities on offer. One person told us about the local scarecrow festival they were contributing to and how they had done exercises one afternoon. One member of staff told us they had to fit activities in and amongst care duties, although there was an activities coordinator once a week. Thy said, "We do the activities. The activities coordinator was in yesterday making bird feeders." They agreed it was difficult to fit activities in addition to providing care for people. On the day of inspection, a person from a book club attended to read with people. Another person was occupied doing a jigsaw on their own. We asked whether people could assist care staff with daily living tasks such as laying the tables, but the manager told us this was not happening at the current time, although one of the cooks did on occasion support people with a baking activity. The provider had a daily plan in place for activities and this was displayed at the entrance of the home. This showed there was a range of activities on offer. However, we were concerned about the lack of meaningful and purposeful occupation for people at other times and relatives we spoke with confirmed this.

We asked the manager how they were implementing the requirements of the Accessible Information Standard. This requires them to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information, which they can access and understand, and receive communication support if they need it. Although they were unaware of the requirements of the standard they told us and we saw a person's communication needs were recorded in their care plan with detailed instructions on how best to communicate with the person. They told us they would implement a policy in the near future.

There was a complaints policy in place and there were signs up throughout the building on how people could complain. There were no complaints recorded formally. The registered provider told us some relatives had identified areas for improvement at the relatives meetings which they had not recorded as complaints, for example, where families had been unhappy about laundering of clothes. They had acted upon these concerns to resolve any issues. However, a couple of relatives told us they had spoken with management about shortfalls in the care of their relative, and it had been dealt with. However, there was no record of any complaints or concerns. This is an area, which could be developed so the registered provider could demonstrate they are tackling performance issues and using this information to improve their service

Inadequate

Is the service well-led?

Our findings

Following our last inspection, we had received an action plan from the provider telling us what action they intended to take to make improvements. We found some improvements had been made but we found continuing issues with records around the management of risk. We had additional concerns about staffing levels and how the home was meeting the needs of people who were at risk from poor nutrition and hydration. The service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as governance arrangements had not been effective in driving improvements.

The service did not have a registered manager in place. There had been a gap of several months between the registered manager leaving and a new manager taking up post. There had been no interim manager in post and the home had been managed by the registered provider and senior staff. A new manager had been in post for six months at the time of this inspection and an application to register had been made shortly before this inspection. We had been concerned with the timeliness of the application to register with us, and had reminded the registered provider that is was a condition of the registration of the service.

Staff told us how approachable they found the new manager. One said, "She is down to earth. She will help us. She'll come onto the floor and help." People's relatives told us they found the registered provider approachable and they always came to chat with them when they were present. Staff all mentioned to us how they loved working at the home and how everyone worked as a team. One member of staff said, "We all get on like a house on fire."

We found there was a lack of clarity about the roles and responsibilities of the registered provider and the manager, which meant when we asked the manager for some information they were unable to locate this until the registered provider arrived. Some quality assurance systems were in place and the manager had completed a detailed audit in relation to staff training. Medication audits were also completed. Other audits highlighted areas requiring improvement, but additional scrutiny of these areas had not been actioned. For example, although risk assessments and care plans had been an issue at our last inspection, only a small number of care plans were audited each month by the management team. A more robust system would have identified where improvements were still required and ensured actions were completed.

We had concerns, the manager was not working to a clear action plan to address the issues at the home following our last inspection, with dates for completion and regular recorded updates. This meant there was a lack of clarity what tasks needed to be prioritised. The provider sent us notes of meetings with the manager, which showed discussions were held about training, records, audits, health and safety and activities. One record stated the requirement to audit one third of care plans each month, but this had not happened. It was not clear that items were followed through to completion from the notes provided. They were not using CQC key lines of enquiry as a tool to audit against, which would have helped to identify where improvements were required.

Policies and procedures had not been updated to reflect current evidence based practice. The manager told us this was on their list of actions to complete.

We found the provider did not have effective quality assurance, information and clinical governance systems in place to drive continuous improvement and manage future performance. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as governance arrangements had not been effective in driving improvements.

Although a dependency tool had been completed, we could find no correlation between this and staffing levels. It was not clear that all factors had been considered to analyse staffing levels including the impact of new and temporary residents on staff and other people at the home.

Maintenance checks were thorough and the registered provider utilised external contractors for electrical testing and gas maintenance. Checks on equipment requiring LOLER checks had also been completed at a time interval specified by the regulations. No one had overall responsibility for the visitors signing in and out book and we found not everyone had been asked to sign in and out and people had not written in date order.

We saw a list of forthcoming residents and relatives' meetings on the notice board at the entrance to the home for the coming year. The provider told us in addition they tried to speak with families and visitors at the home for their views about the care provided. Some of the relatives we spoke with confirmed this telling us they often spoke with the "owner" when they visited the home.

We saw evidence the home had worked in partnership with other agencies such as the community nursing services, GP's, local authority commissioners and safeguarding teams. We received positive feedback about the service from the community health services. The home had involved the health team supporting care homes and from the mental health services.

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 11 HSCA RA Regulations 2014 Need for consent There was a lack of evidence of lawful consent as not everyone had decision specific capacity assessments in place, or evidence of best interest decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was a continuous breach around the management of risks. Risks to people's health and wellbeing had not always been assessed. This meant risks had not been effectively managed and reduced.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs One person's nutritional and hydration needs had not been met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We were not confident there were enough staff to support people at the home with a timely response to their need for care.

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 17 HSCA RA Regulations 2014 Good governance Care records were not all up to date and contemporaneous. The service was not well-led. The provider did not have effective quality assurance, information and clinical governance systems in place to drive continuous improvement and manage future performance.

The enforcement action we took:

Warning notice