Meridian Healthcare Limited

Augustus Court

Inspection report

Church Gardens
Church Lane, Garforth
Leeds
West Yorkshire
LS25 1HG

Date of inspection visit:
18 September 2017
21 September 2017
03 October 2017

Date of publication:
12 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 18 and 21 August 2017 and was unannounced. We extended our inspection due to concerns raised with the Care Quality Commission (CQC) and attended for another day on 3 September 2017. The inspection was prompted in part by notification of an incident following which a person using the service was involved in a serious safeguarding incident. This incident is subject to a criminal investigation. The information shared with the CQC about the incident indicated potential concerns about the management of risk relating to safeguarding and this inspection examined those risks. The provider told us the local authority requested they complete an internal investigation which has now been initiated.

Augustus Court is a residential home providing accommodation for persons who require personal care and people living with dementia. At the time of our inspection there were 57 people living in the home. The provider registered with the CQC in February 2016 and this was their first inspection.

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

We identified breaches of the Health and Social Care Act (Regulated Activities); you can see what action we told the provider to take at the end of the full version of the report. Full information about the CQC's regulatory response to the more serious concerns found during the inspections is added to reports after any representations and appeals have been concluded. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found the registered manager had not acted on safeguarding concerns that had been raised and that incidents and accidents were not always recorded which meant processes were not followed in accordance with the provider's policies and no actions were taken to keep people safe from avoidable harm and alleged abuse.

Statutory notifications were not always submitted to the Care Quality Commission as required. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'.

Risk assessments did not always reflect people's needs. We found two assessments had not been implemented when there was documentation to suggest a risk was present.

We found shortfalls in recording, for example, topical Medication Administration Records (MARs), re-positioning charts were not always signed, accidents and incidents were not always documented on the providers 'Datix' system and complaints made to the service had not always been recorded formally.

Audits were completed however, we could not be confident that these had reflected all that had happened in the home due to the shortfalls in recording and lack of reporting incidents.

People living in the home told us they felt safe and said the staffing levels were sufficient to meet their needs. Appropriate checks were carried out to ensure staff working in the home were safe to do so.

People and their relatives felt staff had sufficient training to do their job and we found training took place with the staff. Staff were provided with regular supervisions and annual appraisals to develop their learning and any new employees completed an induction programme.

We found the provider was working within the principles of the MCA, with completed assessments in place and relevant care plans in situ. We also saw the provider had made DoLS applications when required.

There were mixed reviews about the food but overall this had improved recently. Fluid and food charts were used for people that required further support although, we found these records were not always robustly maintained.

Most of the people and their relatives told us the staff were caring and spoke positively about their relationships.

People told us staff treated them with dignity and respect at all times. We saw people were being supported to be as independent as possible and explanations about a person's care was provided.

End of life care plans were individualised to the person's needs and regularly updated.

Initial assessments and care plans were in place and reviewed regularly. We found that people and their relatives were invited to formal reviews of their care on a six monthly basis.

We saw regular meetings took place with people living in the home to ask for their views and found staff and governance meetings were held.

Surveys had been completed and were overall positive about the home. People living in the home and relatives were provided with annual surveys to complete. Action plans were drawn from this to reflect what the provider and registered manager were doing to support changes, ideas and make wishes and needs a reality at the home.

People and their relatives spoke highly of the activities provided at the home. We saw regular activities, weekly timetables of planned events and monthly newsletters.

The registered manager had positive community links with the local school and put on events to include people in the local community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Topical creams were not always administered in line with the provider's policy and procedure. We found records and guidance were not always up to date to ensure people always received their medicines as prescribed.

Some risk assessments were in place for people who needed them and were specific to people's needs. However, we identified risks for two people which had not been assessed to keep people safe.

People told us they felt safe. Staff received training in how to protect people from abuse and how to respond if they suspected abuse was or had taken place. However, the registered manager had failed to follow their policy and procedure and act on all the concerns we found which meant people may not be safeguarded from avoidable harm and alleged abuse.

Staffing numbers were sufficient to meet people's needs and safe recruitment processes were followed.

Is the service effective?

Good

The service was effective.

Where people lacked capacity to make decisions, care plans evidenced compliance with the Mental Capacity Act 2005.

Staff received regular supervisions and annual appraisals.

There was an induction and training programme in place for staff.

People were supported to meet their nutritional needs and supported to maintain their health with access to professionals, if needed.

Is the service caring?

Good

The service was caring.

People told us staff were caring. Positive and professional relationships had been built with people using the service and staff.

Staff treated people with dignity and respect and they were supported to be independent.

Staff involved people and their relatives in care planning and provided appropriate explanations about their care when required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A complaints procedure was in place. However, not all complaints had been recorded. People using the service knew who to contact if they wished to make a complaint but told us they thought complaints would not be robustly investigated.

People received personalised care and support. They and the people that mattered to them had been involved in identifying their needs, choices and preferences and how these should be met.

Initial assessments were carried out and regular reviews of care took place.

Is the service well-led?

Inadequate

The service was not well led.

We found shortfalls in the lack of record keeping in the service and unsatisfactory documentation to monitor the quality of the service being delivered. We found the registered manager had failed to follow the systems put in place to keep people safe from harm.

Statutory notifications were not always submitted to the Care Quality Commission as required.

Regular meetings took place with people living in the home, their relatives and staff. We saw surveys had been completed to gather people's views on the home.

Augustus Court

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 checked whether the provider was 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 inspection was prompted in part by notification of an incident following which a person using the service was involved in a serious safeguarding incident. This incident is subject to a criminal investigation. The information shared with the CQC about the incident indicated potential concerns about the management of risk relating to safeguarding and this inspection examined those risks. The local authority also requested the provider complete an internal investigation regarding this matter, which has been initiated.

This was a comprehensive inspection which took place on 18, 21 August and 3 September 2017 and was unannounced. On the first day of inspection one adult social care inspector and an expert by experience attended. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two, one adult care inspector attended and day three there were two adult social care inspectors and an assistant inspector.

Before this inspection we reviewed information we held about the service. This included statutory notifications received from the provider and registered manager as not all were reported. Statutory notifications are notifications of certain events and incidents that the provider has to inform the CQC by law. We used this information to help plan the inspection. Before the inspection, the provider completed a Provider Information Return (PIR) and we reviewed this information. 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 also contacted the local authority, local safeguarding team, the police and Healthwatch to obtain further information following concerns raised during the inspection.

During the inspection we spoke with five people who used the service, four relatives, the regional director, the registered manager, deputy manager, wellbeing co-ordinator, one general practitioner, one nurse practitioner, one administrative staff and eight care workers. We also spoke with the nominated individual

following our inspection to request further information.

We looked at a range of records including three staff files relating to recruitment and three staff files relating to supervision, appraisals and training. We also looked at seven people's care records which included care planning documentation, risk assessments and daily records. We viewed records relating to the management of the service, surveys, audits and a wide variety of policies and procedures.

Inadequate

Is the service safe?

Our findings

A whistle blower and other people raised their concerns about the safety of people living in the home and said that insufficient action had been taken to protect people from avoidable harm and or alleged abuse. We looked at these issues during the inspection and found evidence to support these concerns and additional areas of concern around people's care and safety.

The provider had safeguarding procedures and policies in place but when we reviewed daily notes we identified several incidents that had not been reported in line with their process. Incidents had not been referred to the local safeguarding team or the CQC and despite the seriousness of the incidents no actions had been recorded, investigated or mitigated any re-occurrence to keep people safe from avoidable harm and or alleged abuse.

The provider's safeguarding policy stated, 'Where a staff member suspects that a resident may be being abused, or has witnessed the abuse of a resident, they should immediately report this to the Home Manager or to the Designated Person in Charge for the Home who will immediately inform the Local Safeguarding Team and their immediate Line Manager, and copy the information where it is deemed serious to their Managing Director.'

Staff that we spoke with were able to demonstrate their understanding of safeguarding procedures to ensure people were protected from any harm and told us they reported their concerns to senior staff, the deputy manager and the registered manager. We saw evidence of this in people's daily notes which recorded, 'Manager informed' or 'Senior and manager aware.'

We reviewed all safeguarding incidents over a 12 month period and found no safeguarding alerts relating to the alleged abuse recorded in the daily notes. This meant people living in the home may not be protected from avoidable harm and or alleged abuse. The registered manager had not recognised the seriousness of the concerns or escalated the concerns in line with their policy and procedure following local authority safeguarding guidance or informed the CQC with details of the incidents.

In addition the registered manager had failed to implement appropriate risk assessments to protect people from the risk of harm and alleged abuse.

Risk assessments were completed for the majority of people living in the home when this was required, some of these included risk of falls, moving and handling, choking and nutrition assessments. One risk assessment related to a person's risk of falls. This risk assessment had been reviewed and action was taken to stop a medicine as there had been an increase in falls due to the side effects of the medication.

Although we saw some risk assessments being updated we also found two that had not been reviewed or risk assessments implemented when incidents had occurred. For example, we saw a person was a fire risk due to previous incidents of starting fires on their transfer admission form. However, we saw no evidence of any fire risk assessment in their care plan. In addition we saw a communication record which documented a

discussion about a person's inappropriate behaviour towards others in the home. There was no evidence of a risk assessment to monitor how this risk would be managed safely. In addition we found failings to implement relevant risk assessments to protect people from the risk of harm which meant people were not protected. We found two care plans out of seven that we looked at which did not have relevant risk assessments in place.

Accidents and incidents were reported to senior carers, the deputy or the registered manager. The process included the recording of the information onto an electronic risk management 'Datix' system. The system enabled the provider and registered manager to monitor trends and themes that occurred in the home. The regional director told us weekly compliance reports were completed and reviewed to ensure actions had been taken for any incidents reported which, also gave the provider oversight of any concerns in the home. Although some of the incidents we saw had been dealt with and actions taken, we found incidents in daily notes which had not been recorded onto this system. This meant the provider did not have full insight of all of the incidents and accidents which took place in the home to ensure people were safe and that the registered manager had failed to follow the systems in place to report and record concerns.

Prescribed daily medicines were administered and signed by staff or relevant codes used if medicines were not administered. The medication administration records (MARs) we looked at did not state specific times for administration and instead stated 'Morning, Lunch, Tea time.' The staff administered 'As required' medicines for some people. However, there was no documentation of what time medicines were given. We also saw one MAR which did not state why a medicine had been prescribed and when the person would require this. The provider told us they had been experiencing difficulties with the local pharmacy and that they had not documented specific times on the MAR's.

This meant that staff did not know the specific time when medicines had been given which therefore put people at risk of overdose. We raised this with the registered manager who told us they would review all of the MAR's to ensure all documentation was correct and times added to avoid potential errors.

There was a monthly stock check of all medicines however, this was not signed or dated. We discussed this with the deputy manager who said they would implement dates and signatures on monthly stock checks. We also found that daily 'five a day medication stock checks' were completed and focused on one person's medication stock, this ensured all medicines were stock checked every month.

Topical MAR's were not always signed by staff and we found some charts did not document correctly what had been administered. For example, a prescription recorded, 'Apply to both legs twice a day.' However, the person's MAR stated to give 'As required.' We reviewed other Topical MARs from August and again found 20 MARs did not document the correct directions for use as prescribed. Out of 77 MARs starting from 18 September 2017 we found 21 charts that had errors. One topical MAR started on the 18 September had five missed signatures for a pain relief medication. This meant people were at risk of not receiving their topical medicines as prescribed.

We discussed this with the registered manager who told us this was a concern that had been raised and they provided evidence of team minute meetings and supervisions with staff which recorded discussions about medication errors. The manager told us they planned to do weekly audits on the medication charts to ensure people received their medicines as prescribed.

The above concerns were a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Medicines were stored in individual boxes with labels on which identified the person's name, date of birth, dosage and times to be administered. When boxes were opened, times and dates were written on to the box to ensure they were used following the manufacturers guidance. Medicines were stored safely in a locked cupboard, fridge temperatures were completed daily and controlled drugs were ordered, stored and two signatures documented when any drugs were administered.

Staffing levels were sufficient to meet people's needs and rotas reflected this. One staff member and one person living in the home told us more staff were needed but overall people and staff felt there was sufficient staffing levels at all times. The registered manager told us, if there were not enough staff other members would change shifts or opt to do more hours. The registered manager used a dependency tool to determine people's needs and staffing levels required. We saw the registered manager had over staffed at times to allow for annual leave and sickness so shifts were not short. We saw no agency staff had been used by the provider since the home became registered in February 2016.

We looked at staff recruitment records which showed the checks that were undertaken before staff began work. Checks included application forms, interview notes, confirmation of identity, two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff have a criminal record or are barred from working with children or adults at risk and help employers make safer recruitment decisions. We looked at three staff files which had all the above documented.

We completed a tour of the home as part of our inspection. We inspected people's bedrooms [with their permission], bath and shower rooms, the laundry, kitchen and communal areas. We saw fire-fighting equipment was available, fire risk assessments were completed and were up to date, and personal emergency evacuation plans (PEEPs) had been completed for all people living in the home. This meant staff had plans to follow should they need to evacuate people from the home. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant. This meant the provider had completed checks to ensure the home and equipment were safe for everybody.

Despite the concerns we found within the home regarding the safety of people, most of the people living in the home and their relatives told us that they felt safe at Augustus Court. One person told us "I feel safe because the doors are closed and locked at night." Another person said "I feel safe because there is always staff around."

Good

Is the service effective?

Our findings

People living in the home and their relative's told us staff were well trained. One relative told us, "Staff are trained and knowledgeable in the areas they should be, I could not praise them higher."

Induction programmes were completed by new staff and this directly linked with the Care Certificate for which the provider had been awarded the status of centre of excellence by the skills for care team. The induction programme included shadowing of established members of staff, being mentored for 12 weeks to check competencies, completing a work hand book, spending time with the registered manager and other training.

Staff completed annual training in health and safety, food hygiene, infection control, safeguarding, equality and diversity, safer people handling, fire drills and emergency plans. The registered manager had a matrix which stated 96.9% of staff were up to date with their training. Other training included MCA, medicines, dementia [person centred approach], falls awareness, equality and diversity, nutrition and challenging behaviour. The majority of staff that we spoke to agreed that the training was sufficient to meet people's needs. However, one staff member felt further training was required for people who were receiving palliative care and for moving and handling stating, "I don't feel staff have the knowledge to care for them." We discussed this with the registered manager who told us specialist training was available for all staff and that regular training was provided by the home, we saw this documented on the provider's training matrix system.

The regional director told us they had a "learning academy" and staff were encouraged to develop their skills and knowledge with other training such as NVQ's or specialist training for example, blood taking and extended end of life training skills.

We saw supervisions and appraisals were completed and followed the provider's policy. Staff had regular supervisions and told us they felt supported. One staff member said, "Yes I've had supervisions. I talk about my professional development and the manager lets me know what I need to improve on and what I've done well." We also saw people received annual appraisals which meant people could continuously develop their skills whilst working in the home.

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.

We found all care plans contained capacity assessments which determined if a person had capacity. Where people had been assessed as having a lack of capacity to make some important decisions, care plans included information from best interest decision meetings which meant discussions were held about a person's care. Best interest meetings recorded input from people's relatives and involved health care

professionals to determine best possible outcomes for the person. For example, a person had been refusing to take their medicines which supported their health needs. A best interest meeting was then held to determine how best to support the person to take their medicines. We saw that capacity assessments were regularly reviewed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked and found the service was working within the principles of the MCA, and we found any conditions on authorisations to deprive a person of their liberty were being met. We found six applications for a DoLS had been made; these were still being processed by the local authority.

Staff were able to demonstrate their understanding of the MCA and DoLS. One staff member told us, "It's to assess someone's ability to make choices. If someone has capacity, even if we think they have made an unwise decision it's their choice. If we think a person lacks capacity we would involve health care professionals and family to discuss if a person has capacity. If at risk of harm for example self-harm or if a person went out and wouldn't be able to find their way back we would apply for a DoLS."

We observed people at lunch, sitting together and having friendly conversations with each other and staff. Tables were decorated with linen and fresh flowers. Some people were supported into the dining room, others came in independently. We saw people were given a choice of where they wished to be seated; some people chose to sit alone, others with friends.

The kitchen was clean and spacious in size. We looked at the monitoring of the kitchen including fridge temperatures, food storage and menus. Staff followed good practice to maintain infection control. We saw staff washing their hands and wearing aprons and gloves to serve the food. Forms were available to people living in the home to identify their food preferences. The chef was aware of people's individual's needs and specific diets where necessary. The chef said, "If people don't like the food we take it off the menu, we give them what they like. One person doesn't like dairy so we accommodate this."

People we spoke with had mixed reviews about the food. However, improvements had been reported. One person said, "The food was poor but now it's lovely, we have two new chefs, food is individualised, it's good quality and good portions" and another person told us, "I congratulated the chef yesterday, I have been here a week and I have loved every meal."

We saw people had food and fluid charts in place to record their daily intake. This meant the provider could involve other health professionals such as a GP or a dietician where they had any concerns. We found some entries had not been completed. One chart did not state whether the person had met their target for the day and no actions had been documented. We saw the person had not met their target as they had only had 600ml of fluid throughout the day. We also found a number of charts that did not record food or fluid intake after 5pm. We addressed the lack of recording with the registered manager who informed us that this was a recording issue and people did receive food and fluids regularly. The registered manager showed us monthly weight charts for people living in the home and we saw people who had previously lost weight had now gained and were within healthy ranges.

One relative said, "The day mum came to the home she was made to feel very welcome, it was tea time, she was given chicken soup which was very comforting and a selection of sandwiches in her room. Mum has only been here a short time and she has put weight on and her mobility has increased."

People living in the home had a 'professional's communication record' within their files. We saw the dates and times of when health care professionals had attended the home were recorded and what actions had been taken. For example, 'nurse practitioner – visit due to fall in the night and [Name] complaining of pain.' The home also ensured they supported people to appointments if relatives were unable to. One relative said, "My mum had a fall and the staff were great, they went in the ambulance and stayed at the hospital as all her relatives were out of the country. The home kept us updated on how she was."

Good

Is the service caring?

Our findings

The majority of people, relatives and health care professionals spoke highly of the staff team. One person living in the home said, "The staff are brilliant, people look after you very well." A health care professional told us "The staff are caring and knowledgeable; I have no concerns over the care." A relative told us, "Staff have built strong relationships with my mum."

One person, who felt the care from staff could be improved said, "The manager has told staff to introduce themselves, but sometimes they stand at the door and shout and I can't see who they are, the cleaner is very nice; she sits and talks to me."

We observed staff explaining to people living in the home about their care or activities that were due to take place. For example, we saw a staff member explain that she was making a list of people that would like a flu injection; the member of staff explained to the person what this would involve and continued to ask the person if they would like a flu injection.

All the people living in the home told us staff protected their dignity and were respectful. A member of staff told us, "We always knock before we go in, ask what they would prefer us to do, close the curtains, ask if they want us to stay in the room when undressing. I work with a person that I give a face cloth to cover areas to protect their modesty. We also make sure towels are ready for when they need and that their clothes are in the bathroom." The registered manager told us they had 'Dignity Champions' within the home and these staff members promoted best practice with regards to people privacy and dignity.

People in the home and their relatives told us they were encouraged to remain independent and this was evident in people's care plans. For example, '[Name] is able to adjust and position when in her chair and wheelchair.' Staff said, "Some people are capable of doing things, one woman wanted to shower independently and I am there to just support if needed." One relative told us, "I wanted [Name] to remain independent and it felt like an independent place, people are very independent here."

During our inspection we found that some people living in the home were on end of life care. All the care plans we reviewed had end of life care plans and these were completed in consultation with people and their relatives, where appropriate. They recorded people's wishes and preferences should they require end of life care. The end of life care plans were specific to people's needs for example, one person required regular turning to prevent sores as they were unable to get out of bed and checked on an hourly basis to ensure wellbeing, make them comfortable and to ensure that fluid and food had been offered.

At the time of our inspection no person living in the home had an advocate although, the registered manager told us how they would support someone to obtain one should this be required. An advocate is a person who can support others to raise their views, if required.

Information about people was kept securely in the office and staff told us they were aware of keeping personal information confidential and knew how to access this information.

Requires Improvement

Is the service responsive?

Our findings

Complaints were managed through an electronic risk management system called 'Datix.' The registered manager also kept a printed copy of all complaints in a file. We saw complaints had been received and actions taken when required. However, we received information during our inspection that a complaint had been made although; this was not evident in the complaints file or on the Datix system. The registered manager told us they had met with the complainant to discuss their concerns but this had not been recorded on the system at the time of our inspection. We also found information from a complainant on the provider's website which stated, 'Management of the home and head office have still not responded to our complaints and issues and it had been over a month.' One complaint we looked at documented a conversation whereby the registered manager had agreed to respond to the complainant within seven days however, a further written complaint was sent in May 2017 as they had not received any response. The initial complaint was made at the beginning of April with no follow up correspondence which meant the registered manager was not responsive to complaints at all times and did not respond in a timely manner in line with the providers policy.

Staff told us they were supported by the management with their learning and development however, the majority of staff we asked said they would not feel confident that when a concern or incident was raised that this would be managed effectively. Staff told us, "I've reported concerns but nothing happened." The staff member gave an example of when they raised a concern about a person living in the home and made suggestions to reduce the risk however, this was not implemented and no other actions taken. Another person told us, "I feel confident to raise issues but not confident that actions will be taken."

This was breach of Regulation 16 (receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

The people who we spoke with said that they have not needed to raise a complaint but in the event that they did they would feel confident to do so and would speak with the registered manager.

We looked at nine care plans which were personalised, offered choice and were individualised to meet people's specific needs.

People we spoke to and their relatives told us staff offered choice and preference to people using the service. One care plan stated, '[Name] would prefer a female carer to assist with her personal care needs' and '[Name] is able to dress herself and can choose her clothes. [Name] can choose to have her hair done every Tuesday by the hairdresser who comes into the home.' Staff told us, "We offer them choice from admission, we ask how many staff they need, what their morning plans are, if they need any assistance, ask what people like to wear, things like that. For people with dementia they can become overwhelmed with too much choice so we might offer them two choices at a time and if they didn't like that, offer another two so we don't overwhelm them."

People and relatives said they were also encouraged to personalise their rooms. We observed occupied rooms where people had brought photographs and personal items to decorate their rooms which made them feel homely.

We saw initial assessments had taken place to ensure the provider could meet people's needs. We saw regular reviews of care plans took place and relatives were invited to attend. One relative said, "A few weeks ago there was a review of care, I was in France, my brother and sister attended the meeting at the home with the social worker and the memory nurse and the manager arranged for me to link in through Wi-Fi so I was included in the meeting, it was great. We are very impressed there is no comparison to other homes."

People and their relatives reported that there was a good range of activities every day both inside and outside the home. During our inspection there was a trip to Scarborough and previously they had been to Kirkstall Abbey. People reported enjoying the pianist/singer each Friday, exercise classes, pampering, prosecco afternoons and nail treatments.

The provider also included relatives in events and had community links with the local school. One relative said, "We had formal invitations to a garden party a few weeks ago, it was lovely. There was a bouncy castle for the grandchildren and afternoon tea for everyone, the sun was shining it was a lovely day." Other activities included people from the home visiting the local school to attend a nativity play. Children from the local school attended the home at Easter and more recently a pony was bought into the home. The wellbeing coordinator said, "We had a lady on end of life care, we took the pony into her room and the pony laid its head while she stroked it, it was lovely to watch."

We also saw the provider had a hair salon and a gym that people could access. The registered manager told us people were supported in the gym by the wellbeing coordinator and that people were assessed prior to using the machines.

The provider had a designated wellbeing coordinator who arranged weekly timetables and events at the home. The coordinator had a diary which showed all the planned events and documentation in people's care plans of when they had attended and their involvement. The wellbeing coordinator said, "We give people a choice if they want to attend. If they don't I spend one to one time with them. I do a newsletter of the events we have done and include pictures. I give people a weekly activity sheet so they know what's going to be on. Anyone new coming into the home I make sure to try and engage them and stimulate them." A relative told us, "It keeps their mind active and that is really important to keep their physical and mental wellbeing."

One person said, "When I came here the manager asked me what I like, I said I like to watch films, the manager asked me what films, and my favourite is Pretty Women. The manager got me this film and I've watched it in the cinema room, the manager also put subtitles on my television in my room as I am a bit deaf."

The provider had also received a number of compliments. We saw an array of thank you cards and comments left on the provider's website. One person said, "The home is very clean and the staff are very friendly. It feels very homely and welcoming" and another person said, "My mother-in-law has been here three months and moved from another care home locally. She has settled in well and this is due to the staff and especially the range of activities that are organised weekly. The wellbeing coordinator is a great asset to the home. The standard of facilities are excellent. She is very happy and that says a lot about the home."

Inadequate

Is the service well-led?

Our findings

As part of the conditions of the provider's registration with the CQC, we must be notified of certain changes, events and incidents that affect their service or the people who use it. Statutory notifications were not always submitted to the CQC as required. This meant that where needed, we were unable to investigate and where required take appropriate action. We are dealing with this matter outside of the inspection process.

This a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider and registered manager audited health and safety, infection control, medicines, incidents and accidents, falls, care plans and complaints. We found audits were in place but could not be confident that all information had been accounted for. For example, we found the registered manager had failed to identify and include known risks within care plans which had not been highlighted by internal audits. This meant audits were ineffective to ensure people's safety. We also found medication audits were completed but not always effective to drive improvement. For example, we saw timings had not been documented when PRN [as required] medicines were administered; this was highlighted in the action plan to address. However, we found several MARs that had not recorded the times following this action plan. Systems and processes were not followed and therefore failed to identify the concerns we identified during the inspection.

We found shortfalls in the lack of recording in a number of areas in the home. This included a lack of recording regarding the use of topical MARs, fluid and food charts and re positioning charts. This meant the registered manager had failed to maintain accurate, complete and contemporaneous records.

We also found several incidents including serious safeguarding concerns recorded in people's daily notes which had not been documented on the provider's accident and incident forms to ensure actions were taken to reduce any risk in the home. We found failings in the registered manager's approach to managing and minimising risk to people which meant people could be at risk of potential harm.

Safeguarding concerns were not appropriately managed and risk assessments were not documented to reflect people's needs. Incidents in the home were not always recorded and therefore actions to reduce risk were not implemented. Audits were ineffective and failed to monitor people's safety within the home as not all incidents were reported and acted upon.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

We saw the staff survey was last completed in June 2017 however; the provider had not yet correlated the results of this. The last relative survey from June 2017 showed 62% of relatives thought the home was excellent, with 23% rating it as good and 15% as average. People living in the home completed a survey in June 2017 with a 100% rating of excellent; this was based on one survey being completed. We saw the results from this survey had actions taken which included the registered manager arranging resident and

relative meetings, regular staff meetings to communicate any issues, manager to hold a manager's surgery on a Monday for residents to ask questions, monthly newsletters and for all departments to participate in resident of the day.

The home had a computer in the entrance which allowed people to leave feedback; it was called 'Have your say.' The provider also had a feedback portal for people to leave their reviews online. The registered manager told us, the information received from these systems allowed the home to make changes to improve the service.

The home had a 'Resident of the day' which meant the person's overall care package was audited and reviewed, a deep clean of their room took place and they were asked for their views on the home and if any improvements needed to be made.

We saw meetings took place with people in the home, staff and the registered manager told us quarterly governance meetings took place. The registered manager also provided a 'home manager's surgery' which allowed given time for people using the service to come and discuss any concerns with the manager. Monthly resident meetings included information on activities that were taking place, meals, staffing levels and future plans for the home. Monthly staff meetings focused on training, outstanding actions such as improvements to record topical medicines, annual leave, communication and respect for others.

The registered manager told us bi-monthly out of hour checks were completed at weekends by the regional director or themselves to check people were safe and all records completed, this was started in July 2017. The registered manager said if any concerns were raised during these visits a 'lessons learnt' would be completed and concerns discussed in the provider's governance meetings with actions taken to ensure this did not happen again.

The provider and registered manager had positive community links with the local school and often participated in events with each other. We spoke to a teacher at the school who told us the registered manager had made links last year and since then such events had taken place, Christmas parties, Easter events, reading groups and open days. The teacher told us, "The relationship with the home is good and the children and the residents have benefitted from the links. The children know the importance of respecting and caring for older people."

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 There was a failure to implement risk assessments when serious risks had been raised the provider and registered manager did not do all that was reasonably practical to mitigate any such risks. There were also failings to ensure the safe management of as required medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager failed to respond to complaints in a timely manner and failed to record all complaints, outcomes and provide actions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager failed to follow systems in place to assess, monitor and improve the quality and safety of the service provided. There was failure to maintain accurate and complete records.