Wellmun Care Limited

Two Gates House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

This unannounced inspection took place on 14 and 15 June 2017 and was unannounced.

At our last inspection of the service in July 2016 we found that the provider was meeting regulatory requirements and the overall rating for this service was Good.

Two Gates House provides accommodation for up to 32 older people some of whom have a diagnosis of dementia. At the time of our inspection 29 people lived at the home. The home had 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 and associated Regulations about how the service is run.

The use of unsafe equipment had placed people at risk of harm. Risks to people's health and safety were evident due to trip hazards which potentially could cause people to fall. Worn equipment had not been checked sufficiently to ensure it was safe for use. Risks were not consistently assessed or managed which meant some people were at risk from avoidable harm. People's care plans and risk assessments had not always been reviewed or updated and action had not always been taken to mitigate the risk of future events. People's medicines were not managed safely or always administered at the intervals needed. People told us they felt safe and staff knew how to report concerns about people's safety. Dependency levels had increased but there were sufficient staff to meet people's needs. Recruitment practices required improvement to ensure references and health declarations were obtained.

The provider had not identified a number of areas of the service provision that were not meeting the requirements of the law. The systems used to monitor the quality of the service had not been fully effective in identifying concerns to people's safety and people continued to be placed at risk of harm. Risks or changes to people's needs were not always escalated and there were delays in the registered manager taking action to mitigate risks to people's safety. The provider had a history of ineffective monitoring and audit processes previously in June 2014. This improved in 2016 but we found at this inspection they had been unable to sustain good governance arrangements or the progress they had made.

Action had not been taken in line with the expectations in place to comply with the regulations related to the Duty of Candour. This regulation requires providers to be open and transparent with people who use their service and other relevant people. It sets out specific requirements that providers must follow when things go wrong with people's care or treatment. We identified shortfalls with how the Duty of Candour regulation was applied to a specific incident within the home.

Staff were supported in their roles through induction and training. Some training gaps were identified which the provider had plans to address. Staff did not always use their training effectively so people had been moved in way that increased the risk of injury to them. People enjoyed the meals provided and had positive

support and encouragement. Staff sought consent from people and had some knowledge of the Mental Capacity Act (MCA) (2005). However staff struggled to ensure a balance in protecting people's basic rights and taking action where people's decisions put them at risk of harm. Where deprivations to people's liberty had been identified the relevant applications had been made.

People described staff as kind and caring. We saw staff were attentive and interacted with people and were respectful towards them. People's dignity had been compromised by practices in the home which had not been recognised as an issue of dignity. People were supported to maintain their independence and visiting times were flexible to enable people to have regular contact with their family and friends.

People's care plans reflected their preferences and the way in which they preferred their care to be delivered. Some further detail was needed to ensure people's specific needs were planned for. People were supported to take part in a range of activities they enjoyed. People's views about the service were sought and the provider had acted on their feedback. The provider had a system in place to respond to people's complaints and whilst some people told us they were confident these would be addressed, there was some inconsistency in resolving people's concerns.

The provider was working with a number of agencies in order to rectify the shortfalls identified. The provider had also agreed restrictions on admissions until such time the service was safe.

The overall rating for this service is 'Inadequate' and the service therefore in 'special measures'. The service 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. 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.

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.

The provider had not ensured that the premises were free from hazards or that equipment used to support people's mobility was safe for the purpose it was used. Risks had not been assessed and/or managed to reduce the risk of avoidable harm.

People's medicines were not managed in a safe way to protect them from avoidable harm.

Recruitment practices did not consistently include required references and health declarations.

People felt safe and staff knew how to report abuse. However people's safety and well-being was compromised because concerns had not always been escalated or acted upon.

Is the service effective?

Requires Improvement

The service was not always effective.

Competency checks had not been carried out to ensure staff applied their training effectively when meeting people's needs. Some gaps in staff training were identified.

Staff ensured they sought people's consent before they delivered care. Where people's choices potentially put them at risk this needed to be recorded.

People were encouraged to eat and drink enough and told us they enjoyed their meals. People had access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive support in a caring way as their dignity had been compromised and they were moved in an unsafe way.

There was a lack of care with regard to ensuring people's walking aids and other equipment was well maintained to support their dignity and independence.

People were involved in decisions about their care and treatment and described staff as caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people had confidence in the provider's ability to respond to and resolve their complaints, concerns about the quality of care had not been investigated thoroughly.

People's care plans reflected their individual needs and preferences but lacked additional information about specific health needs.

People were supported to take part in a range of activities they enjoyed.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The provider's audits and monitoring had failed to identify risks associated with the premises, equipment and medicine arrangements. People continued to be placed at risk because risks to people's health, safety and well-being had not been identified or addressed by the registered manager.

The management style was reactive with poor communication and a lack of risk oversight.

Two Gates House

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection of Two Gates House commenced on 14 and 15 June 2017 and was unannounced. The inspection team consisted of two inspectors and a pharmacist inspector.

The inspection was prompted in part by a notification of an incident following which a person using the service sustained a serious injury and died. In addition we received a second notification of an incident regarding a person using the service who suffered a medicine overdose. The information shared with CQC about the incidents indicated potential concerns about the management of risk of falls from moving and handling equipment and unsafe medicines management. This inspection examined those risks.

We reviewed the information we held about the service. This included notifications sent to us by the provider. Notifications are forms that the provider is required to send to us to inform us of incidents that occur at the home. We also requested and received information from the local authority who monitor the service to seek their feedback, including any information they held about complaints or safeguarding investigations. We received information from the local authority manual handling team and the health and safety advisor. We used this information to help inform our inspection planning.

We spent time observing the care and support being delivered by staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine people, two relatives and one visiting healthcare professional to seek their views on the service.

We also spoke with five staff, the registered manager and the provider. We reviewed records, including six people's care files, two staff files, staff training records, accidents and incident records, daily reports, communication logs and quality assurance audits completed by the provider. We also looked at how medicines were managed by checking the medicine administration records for eleven people, speaking to

care staff and observing medicine administration rounds.

Inadequate

Is the service safe?

Our findings

We undertook the inspection following receipt of concerning information about people's safety related to how they were supported to move around the home. We were informed a person fell from a commode chair whilst being moved by staff. Following the incident specialists from the local authority had attended the service to assess the equipment used in the home. They found that the commodes did not have footplates and were in poor condition. There were no records to verify that the commode chairs had been inspected to show they were safe to use. They also advised that wheeled commodes should only be used for moving people short distances.

Staff told us they had used commode chairs to transfer people from the lounge to the toilets. A staff member told us, "We used to use commodes (the sort that goes over the toilet) because it reduced the amount of hoisting". Another staff member said, "We've been told not to use commodes now; we had used them to reduce hoisting and possible discomfort to people from hoisting, but not now". We found that the use of commode chairs had not been risk assessed to show this was a safe and appropriate piece of equipment to transfer people from one area to another. A commode chair does not have footplates or a safety lap strap as a wheelchair would and placed people at potential risk when in transit. The provider had not demonstrated that they had considered these factors and taken them into account when deciding to use commode chairs to transfer people over a distance. Therefore this had placed people at risk of avoidable harm.

The provider told us that they had ceased the use of commode chairs for transferring people. Staff confirmed new practices were in place and that wheelchairs were used for all transfers which we saw throughout the inspection. The provider had informed us that a raised area in the join of the carpet had caused the wheels of the commode chair to stick. Whilst repairs had been made to the flooring the provider had not carried out checks to the flooring prior to the accident to identify any potential risks. Since the accident and the local authority inspection visit, action had been taken to address these issues.

The local authority health and safety advisor had provided us with a report following their visit that identified some environmental issues with other uneven surfaces which could be potential hazards to people's safety. We also identified additional uneven flooring in the dining room an area regularly frequented by people; which the provider was unaware of. We found the provider had failed to ensure that people were safely supported using equipment that was fit for purpose and although there had been a great deal of input from supporting agencies, they had not shown that they were taking vigorous action to identify and address risks from equipment and premises themselves.

The provider carried out visual checks on the environment and equipment used such as wheelchairs, hoists or walking aids. We found these checks were inadequate as they had not identified that equipment was rusty and some people's walking aids required attention to ensure a safe grip. The provider acknowledged that their checking systems were inadequate in determining the safety of the premises or equipment which we found could result in people being placed at risk of potential harm and/or injury. Although the provider had taken some action on some areas of the home they had not completed all the improvements needed to ensure the premises and equipment are safe.

We looked at how the provider assessed and planned for identified risks to people's safety. We found risk assessments did not contain accurate up to date guidance to staff as to the equipment people needed to keep them safe. This could lead to inconsistent practice in relation to manual handling of people. For example one person's assessment stated one staff member was required but we saw two staff attending to them. A staff member told us, "We support with two staff". A second person's risk assessment had not been updated to reflect the change in equipment used for them. A third person's assessment told us, 'Is able to mobilise independently with one staff'. Our discussions with staff confirmed that a wheelchair was used but this was not documented. We saw on day one of our inspection that another person was fitted for a smaller sling. On day two we checked and found this information had not been updated in the person's risk assessment or recorded in the communication book or the handover book to ensure consistent practice by staff. There were some environmental factors that had not been included in people's risk assessments so that these were specific to the individual. For example we saw a person with a walking aid using the ramp independently both with their aid and at other times without it. Staff we spoke with confirmed the person needed assistance on the ramp to ensure they had their aid and used the handrail. This was not always happening and this information was not in the person's risk assessment. Our findings indicated people may not always be protected from risks to their safety.

People told us that they had no concerns about getting their medicines. One person said, "I'm happy with the staff doing these and know which tablets to take and I would know if they were wrong ones, they are not though". Another person told us they had access to painkillers when they needed them; "They ask if you want them". Whilst comments received were positive we found deficiencies in medicine administration records (MARs) meant they did not demonstrate people received their medicines as prescribed by their doctor. For example, we found staff initials were missing so we were unable to establish if the medicines had been administered. The receipt of medicines was either not recorded or recorded inaccurately and the provider was not taking into account the transfer of medicines from one medication cycle to the next. This meant without an accurate starting point it was not possible to evidence people were receiving their medicines correctly. For example, one person had been prescribed an antidepressant solution and comparing the records with the quantity found we found more than there should have been.

We observed some good administration practices took place during the morning and lunchtime medicines administration rounds. However we found staff were not aware some medicines needed to be administered at specific times to ensure they were fully effective. For example, the administration of an antibiotic medicine was going to be administered immediately after lunch. This particular antibiotic needed to be taken one hour before or two hours after meals. Another person needed one of their medicines administered at specific times during the day and when we spoke with them they told us that of the five doses prescribed two of them would be administered later than the time specified.

The provider was not always recording the location of where pain relief patches were applied to people's bodies. We found staff were not following the manufacturer's guidelines on rotating these patches around the body. This meant the patches were not being applied safely and could result in the person experiencing unnecessary side effects.

Medicines were not stored securely. We found topical medicines were stored in people's rooms which meant people using the service could inappropriately use these medicines. We also found the MARs for the topical medicines were not able to demonstrate they were being applied in accordance with the prescriber's instructions. We spoke with a person who had been prescribed a pain relief gel for their shoulder. This person told us that their shoulder was painful and confirmed their pain relief gel was being applied "once or twice" a day when it had been prescribed as a three times a day application.

The temperature of the refrigerator used to store medicines was not being monitored correctly. The provider could not demonstrate medicines stored in the refrigerator were being stored at the correct temperature to ensure the safety and effectiveness of the medicines. The refrigerator was storing temperature sensitive medicines.

Some medicines had been prescribed on a when required basis did not have any written information to support staff on when and how these medicines should be administered. Where information was available to the staff in the form of a protocol we found the information was not detailed enough to ensure that the medicines were given in a timely and consistent way by the staff.

We found that medicine management was unsafe and issues had not been identified and acted upon by the provider.

The service places people at on-going risk of harm from the issues identified and although they had removed some of these risks they were not actively identifying other potential hazards and were over reliant on others to do this for them.

The provider had failed to ensure that the premises and equipment used were safe and that risks to people were assessed and that people's medicines were managed safely. This is a breach of regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the care of staff. One person described how staff supported them to walk safely and said, ""They're wonderful girls they earn their pennies". We saw staff assisting people to move using stand aids and hoist equipment and this was completed safely with encouragement to people to reassure them. We asked a person how they felt during this transfer and they said they "felt safe". We saw people had pressure relief equipment in place to reduce the risk of developing sore skin. A visiting health professional told us they had no concerns about staff knowledge or staff alerting them to changes in people's skin. They also confirmed that staff attended with the nurse so that any recommendations about the person's care could be shared. We saw that people being cared for in their bedroom were positioned in bed according to their care plan and staff we spoke with were aware of the frequency of positional changes needed.

People told us they felt safe from the risk of abuse. One person told us, "It's a nice place and the girls are nice, they would never harm us". Some people we met were less able to verbally express their feelings and experiences. During our observations we saw that people were relaxed and smiled in the company of staff. Staff were able to give examples of the different types of abuse and their role in protecting people. A staff member told us, "Any concerns we have we would report to the manager". Records showed that staff had received safeguarding training. The registered manager was aware of her role and responsibilities in raising and reporting any safeguarding concerns. Notifications had been sent to the local authority and CQC as is required. Staff told us that they felt recent improvements within the home would help to keep people safe. One staff member said, "I think using the wheelchairs with footplates, new slings and new risk assessments will improve people's safety".

People told us they had no concerns about staffing levels; although staff were busy they got help when they needed it. Staff told us staffing levels had recently increased due to the higher dependency needs of some people. The provider confirmed that there were increased demands on staff and she had taken account of this. One person told us, "The staff are lovely; very helpful". Another person said, "If I need them they come, there's always someone around". We saw staff were visible in the two lounge areas. On occasion there were short periods where the room was unsupervised and on one occasion a person who required assistance to

walk was doing so without their walking aid. We shared this with the registered manager who told us that the lounge areas should always be staffed. Staff said they could meet people's needs and we saw that staff did not rush people; they were attentive and took their time.

The registered manager told us that she completed checks before staff commenced working in the home. We saw checks with the Disclosure and Barring Service (DBS) were undertaken. A DBS check identifies if a person has any criminal convictions or has been banned from working with people. However we identified some shortfalls with the process for the two most recently employed staff. Only one reference had been obtained but there was no record to state if this was because the registered manager considered this to be from a reliable source. We also saw that health declarations had not been obtained for both staff.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received regular training in a variety of subjects relevant to people's needs. One staff member told us, "I did all my standard training and training in diabetes and pressure relief". Staff confirmed they were up to date with manual handling training. One staff member told us, "The manager does that, she talks us through it and does a demonstration using the equipment". Another staff member told us, "We use a lot of different equipment; stand aids, slide sheets, support belts and the hoist, the manager demonstrates them. We discuss who might be unpredictable so that when we use equipment we can be prepared for sudden movements".

Although records showed staff had received training in manual handling we found this was not consistently demonstrated. For example the registered manager had recorded in the communication book that staff had used unsafe under-arm lifting. Although the registered manager told us that she spoke to the staff member about this she confirmed that there was no record to reflect that she had checked staff competencies to ensure they applied their manual handling training effectively when meeting people's needs. The fact that equipment used to transfer people to the toilets had not been assessed as appropriate to meet their needs safely also showed that manual handling training was not consistently applied or demonstrated and had resulted in injury.

The training matrix was not up to date in relation to pressure care training; we saw less than 50% of staff had done this training. The registered manager told us some staff had attended an in-house session and that she had arranged for further training for more staff with the tissue viability nurse. We noted several staff had not completed training in diabetes which was relevant to people's needs. The registered manager said that where staff missed original training sessions she organised alternatives and she was sourcing further training from the diabetic nurse.

Staff told us that they had supervision regularly and felt supported by the registered manager and provider. We saw that dates for supervision were planned in advance which would allow the registered manager to prepare any issues that needed discussion but with regard to the under arm lifting we did not see any record that the manager had checked staff practice to ensure it did not happen again.

People told us that they were happy with the way staff cared for them. One person said, "They know how to lift me; they use the stand aid I have no worries when they help me". Another person told us, "They assist me; because of my arm I need help, they are very good". Our observations showed that staff used safe techniques when using equipment such as the hoist, stand aids and wheelchairs. Staff told us their practice had recently improved and that they were working in a safer way with the proper equipment.

Staff told us they had an induction which included initial training in key subjects specific to their care role. A staff member told us that their induction included the opportunity to shadow more experienced staff. The registered manager told us that they had recruited some new staff and where staff had no prior training or care experience they would complete the Care Certificate. The Care Certificate is a set of nationally recognised standards to equip new staff with the knowledge they require to provide safe and

compassionate care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 staff were working within the principles of the MCA. Staff regularly sought people's consent before assisting them. People told us staff always asked them first and explained to them before doing anything. One person told us, "I can and do refuse; they're pretty good will ask again when I'm ready". Staff had received training and updates in relation to the MCA and DoLS and were able to give us a good account of seeking people's consent. They also recognised that some people lacked capacity and were aware of the restrictions in place. The registered manager had identified and applied for DoLS authorisations for people who needed their liberty restricted for their safety and staff were able to identify who was restricted in this manner. We observed people had freedom of movement and that furniture was not obstructing this, for example people's walking aids were within reach so that they could enjoy their liberty. Staff identified some people who would refuse care interventions. Where people have capacity but their choices potentially put them at risk this needed to be recorded to show how best interest decisions were reached. For example if people refused the use of equipment such as a hoist, staff had used other equipment which presented risks to people's safety. Additionally they had not risk assessed this equipment or considered advising the person that it was against health and safety to use such equipment.

People told us they enjoyed their meals and always had a choice. One person said, "I do enjoy the food and if I want seconds I can". We saw two sittings took place so that people who required assistance to eat had the support they needed. We observed people had one to one assistance and lots of encouragement to manage their meals. A recent dietician visit had taken place and the recommendations from this had resulted in high protein/high calorie options being made available to people. Staff were aware of people's dietary needs and any risks associated with eating. We saw people's weight was monitored to ensure any nutritional risks to them were identified. Weight records were evident for people whose care we looked at and they had sustained their weight. However some improvement was needed to ensure people's weight was taken at the intervals recommended in order to inform their care plan. We saw people were offered a variety of drinks throughout the day. Staff were aware that the period of hot weather prior to the inspection might pose a risk for some people and told us they promoted drinks.

People told us their health needs were met. One person confirmed, "I see the doctor and the dentist when I need". Another person confirmed they saw the nurse on a regular basis and told us, "I have a dressing on and the nurse comes to dress it". We observed the dressing was clean and dry. Where people had specific health conditions staff were able to describe the importance of eating on time and in line with their specific medication regime. Although generic information was evident with regard to the health conditions for two of the people, there was no specific plan in place so that staff were alerted to the signs of a medical emergency or other health issues that could be exacerbated by this condition. The registered manager told us she would seek information from the relevant health professionals to develop these.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff treated them with kindness and consideration. One person said, "Staff are lovely, very helpful and very pleasant". Another person said when pointing out a staff member, "She is lovely, she needs a medal". Although we saw that individual staff were kind and caring towards people, the provider's systems and processes had not identified the potential risks to people from worn, rusty commodes which did not reflect a caring approach.

We observed the interactions between staff and the people living at the service and noted that staff engaged with people in a positive and encouraging manner. They showed empathy and understanding towards people. For example we saw a staff member constantly encouraging a person to use their walking frame to mobilize and could appreciate the effort the person was making. Staff said "You're doing really well". They took time with the person and praised them for their efforts, "You did really well". However in contrast we identified the provider had not always ensured the safety of people. For example staff had moved people in a way that could cause them harm and which was not in line with safe manual handling techniques. In addition staff had not consistently escalated concerns about changes to people's care; specifically the use of equipment and a near miss to ensure they could meet people's needs in a caring way.

People also told us that their privacy was protected, for example staff knocked their door and waited for a response. We saw staff took account of people's privacy by closing toilet and bedroom doors when supporting them. People told us staff were respectful towards them. One person said, "There's no one who rushes you because I am a bit slow you know". We saw staff spoke with people in a respectful manner and did not rush them.

Staff had some understanding about ensuring people's dignity was respected. One staff member told us, "It's about always ensuring they have help with their appearance, have privacy, making sure you cover them so not exposed or embarrassed". We saw that staff supported people in this way. However there was a lack of understanding on the provider's part in ensuring staff practices protected people's dignity. For example a recent practice within the home demonstrated that staff had not always acted in a way that was respectful or dignifying for people by bringing commode chairs to the communal areas so that people could be taken to the toilet. Whilst staff told us this was done with the intension of reducing the amount of lifting people may have to experience, they were unaware that this practice, apart from being unsafe, did not promote people's dignity. One staff said, "I never thought of that". Whilst this practice had ceased it demonstrated a lack of understanding of protecting and promoting people's dignity.

People said that staff cared for them by for example manicuring their nails and putting nail polish on. A person said about the home, "I like it, I'm comfortable". We saw a number of occasions where staff interacted with people took their time, were polite and friendly. We noted that people had all been well supported with their appearance and people confirmed this, one person telling us, "They are gems; lovely staff".

Where people showed signs of distress staff talked with them and comforted them in a tactile way; giving

hugs and holding their hand, we saw people smiled in return. Some people showed signs of agitation and distress and staff were able to provide a good account of how they calmed them. We saw they used distraction techniques with one person such as offering a cup of tea and a biscuit and asking them if they wanted to "Come for a little walk" which calmed the person. We also heard from a relative how staff had been sympathetic and had showed compassion to them and their family. One person told us staff would, "Chat with you if you want them to". They also named a particular staff member who they described as, "Most helpful".

A person told us they had good relationships with the people they lived with and said the home met their expectations; "Very good, staff very kind and caring and they listen". We saw people exercised control over where they preferred to sit; some people told us they enjoyed the peace and quiet of the conservatory and they were comfortable with their friends in there. People were supported to maintain the relationships that were important to them and said that their visitors were always made welcome.

People confirmed they were involved in making decisions about their care and treatment. One person told us, "I can choose whether to have a bath or shower; there's always a choice". People said that staff discussed their support with them on a monthly basis. One person said, "They bring the plan and go through it and check with me it's alright". Another person told us, "Oh they are very good; they know my routine and follow it and will ask if there's anything else they can do for me". Staff told us they involved people in day to day decisions and people confirmed they chose their own clothing, what they ate and when they did things. We heard staff referring to people by their preferred name which showed they respected people's decisions. Staff told us and we confirmed from records that where people could not fully express their daily preferences their likes had been explored with family members so that their preferred routines were personal to them.

Contact details were available in the home where people may need the services of an advocate to represent their views.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they could raise everyday concerns with the registered manager and provider with confidence that they would be addressed. Information about complaints was displayed and was in a format suited to people's needs to aid their understanding. People and visiting relatives we spoke with had no complaints about the service. The provider could not find the complaints records but did provide examples following the inspection which demonstrated the complaints they sent to us had been responded to. However the family of a person who had lived at the home told us their concerns had not been addressed. We requested a record of the investigation into their concern but the provider did not have one. Minutes of meetings with the family did not demonstrate that concerns about the quality of care received by the person had been investigated thoroughly. There was no record of the outcome of the investigation or changes implemented to improve practice. We found that although there was a complaints process this was applied inconsistently.

People's views about the home had been sought via surveys, meetings and compliments. These had been analysed and fed back to people. We saw feedback was positive showing people were happy with their care. We also saw the provider had responded to people's comments by for example increasing the availability of entertainment brought into the home.

People said they were asked about their care needs on arrival at the home. Staff told us an assessment of needs was undertaken to determine people's needs and how these should be met. Our discussions with people clarified that care was responsive to their needs. However, where people had specific health care needs their care plan provided no or little instruction or guidance as to how their medical condition should be managed. Staff we spoke with were aware of these medical conditions but not fully aware of signs or symptoms to look for. This could mean if a medical emergency arose staff might not recognise this.

People we spoke with told us that staff were responsive to their requests. One person said, "All the staff are great; if I want staff they come quickly". Another person told us they had previously stayed at the home for a short period and had returned to live there because, "It's a nice place and the girls are nice".

People said staff knew them well and that they had their care in the way they wanted. One person told us they had been supported to remain independent for example they showed us a key to their own room and told us, "I can go to my room when I want, I have my own key". Another person told us the service was responsive because they had a choice of sitting in a quieter area such as the conservatory.

People were actively involved in developing their care plans. We saw staff had responded to and involved people in these planning processes. For example we saw one person's records recorded that, "I like to wash in the en-suite as opposed to on the bed, and I like my body spray put on afterwards". Another person's plan said, "I like to shave myself and comb my hair, I will tell you what clothes I like to put on". Staff were able to tell us about people's individual choices and preferences and we saw that these were recorded in people's care records. This showed a person centred approach in which staff tried to ensure what the person wanted was known and supported.

People and their relatives told us they were asked on a monthly basis about their care and had access to their plan to ensure it was responsive to their needs. A person told us, "Staff always talk to me and ask if anything has changed, they bring the plan with them and we go through it".

We saw that staff were responsive to the changing needs of people. A visiting nurse told us that three people needed increased hourly turns and that, "As we have asked (staff) to increase times staff have done what we asked". We saw staff were responding to the increased needs of people. One staff member said, "We've never had three people cared for in bed before; we are still making sure everything is done for them; I think they get really good care". We spoke with the registered manager about how she ensured people's needs could continue to be met when they had increased. She told us she was reviewing two of the three people to see if they could continue to meet their needs. A relative told us they could not fault the efforts of staff in responding to their family member's increased needs. They said, "They have put everything in place and talk to me when things change". We saw staff responding to people on a regular basis ensuring they were comfortable and that they had support to change their position.

Although staff told us that they handed over information between shifts we found this was not effective. For example in one instance the change to the equipment to be used for one person was not recorded. In another instance a near miss incident had not been escalated to the registered manager for action. We found therefore that the platforms for handing over information did not work sufficiently to ensure staff were aware off and could respond to changes and risks associated with people's care effectively.

We observed a lively keep fit session and saw people were genuinely looking forward to the instructor arriving. The session was fun and inclusive. People told us they enjoyed different activities; visiting entertainers, board games, music and crafts. Some people enjoyed the peace and quiet of the conservatory and told us they had their newspaper delivered, did cross words and read books from the library. One person showed us their books in which they did art work. Staff told us they tried to plan in theme days and celebrated birthdays and significant events. We saw staff were attentive to people who preferred one to one contact and that some people had preferred comfort items that were important to them which staff acknowledged. One person told us, "I go in garden if I wish, they tell me what's going on in other lounge and I do go up; there was some girls singing and dancing and I really enjoyed it". Staff told us that the activities that were provided been determined by the interests and support needs of people and we saw some of these had been explored in people's care plans thus ensuring they had their personal interests addressed.

Inadequate

Is the service well-led?

Our findings

Our findings showed the provider did not have effective governance systems in place to assess the quality and safety of the service. People had not always been protected from avoidable harm because the premises and equipment used were not maintained sufficiently to prevent risks to people's health and safety. For example, worn and frayed carpet joins were a potential trip hazard. The provider had failed to identify trip hazards during their audits of the premises.

The provider had used equipment such as commode chairs which had not been assessed for the purpose for which they had been used. Alongside this the commodes inspected by the local authority health and safety advisor were found not fit for use. The provider's audits had not identified where some equipment was worn or where environmental factors may present risks to people's safety.

We found errors in the management of people's medicines. A recent incident concerning unsafe practice with people's medicines had led to a person experiencing an overdose of their medicine. The provider's own audits of medicine practices had not identified the shortfalls we saw.

These issues should have been identified during routine audits of the service but had not been. This showed that the systems in place to audit and check the safety and quality of the service had not been sustained or been effective and the safety of people had not been assured. The provider and registered manager agreed monitoring and audits undertaken by them had not been sufficient.

There had been a higher than average reporting of serious injuries in comparison to care homes of a similar size. We found shortfalls in how the provider managed and monitored falls. For example there were a number of falls not accurately recorded or missing from the record. In one instance a person's fall was recorded but not the injury sustained. Another person's fall and injury was not recorded. The registered manager told us she completed this record but was unable to explain these omissions; therefore any analysis based on the record would be inaccurate. The provider told us they had not identified patterns or themes and we saw there was no analysis or investigation where people had fallen more than once. For example why/where people were falling or specific points in the day where people may be more vulnerable, or looked at whether staff were in the vicinity to ensure people had the support they needed. This was further exacerbated by the lack of information in people's risk assessments and on occasion staff not following risk assessments such as the person using the ramp without their walking aid or staff support. This meant inconsistency in the management of the home and poor oversight of risks which indicate there is continued risk to people's safety. We did note to reduce risks to individuals equipment was identified but as reported earlier this was not always documented.

We found there was a lack of effective systems to escalate concerns. The formal methods used to share information such as the communication book and handover book were not used to share and escalate risks about people's care. The registered manager had not reviewed or taken timely action to follow up three incidents that had been recorded where there was potential for people to experience harm. This meant

people were still potentially at risk from inconsistent practice. We also found that people's care plans did not always contain information related to their specific health needs.

We found care practices for people did not change quickly enough in line with their needs. For example the delays in taking action in relation to the 'near miss'; indicating leadership was reactive rather than proactive. In addition how the registered manager arrived at decisions such as to use commode chairs as a means of moving people between the lounge and toilet areas, questioned their ability to take into account other factors such as the risks involved or how this compromised people's dignity. These shortfalls showed inconsistency in how the home was managed and monitored.

The provider had a history of ineffective monitoring and audit processes previously in June 2014. This improved in 2016 but we found at this inspection they had been unable to sustain good governance or the progress they had made.

Failing to ensure effective governance systems to monitor the quality and safety of the service and mitigate any risks to the health and safety of people using the service is a breach of Regulation 17 of the Care Standards Act 2008. Care Homes Regulations 2014.

The leadership of the home was unclear. The deputy was on long term sick leave. The registered manager said that the lack of a deputy had an impact on her capacity to complete management tasks. However she had not taken any action to rectify this. The senior staff did not undertake specific management tasks and there was a lack of delegation to ensure tasks were completed and that staff had consistent leadership and direction. The registered manager told us she recognised this was an area they needed to improve.

The registered manager was aware of the Duty of Candour. However we identified issues with how this regulation was applied to a specific incident that had occurred within the home. A review of the records provided by the registered manager related to this incident failed to provide evidence that action had been taken in line with the expectations in place to comply with the regulations related to the Duty of Candour. The Duty of Candour requires providers to be open and transparent with people who use their service and other relevant people. It sets out specific requirements that providers must follow when things go wrong with people's care or treatment.

Failing to ensure candour, openness and honesty is a breach of regulation 20 of the Care Standards Act 2008. Care Homes Regulations 2014.

People told us that they saw the registered manager and provider on a daily basis. We saw that people knew them well and used first name terms. People considered the home was well-led because they could speak to the registered manager every day. We saw that interactions between people and the registered manager were friendly and positive. A person who lived in the home told us, "They are very nice and will do anything for you". People told us that they had meetings in which they could discuss things such as meals, activities and day to day issues. People's views had been sought via surveys and we saw the majority of people's feedback was positive. Staff told us they had regular meetings and that they were supported in their role with training and supervision. Whilst staff described the culture within the home as open and transparent, in practice key decisions had been made which led to poor outcomes for people. This indicates a lack of understanding of good practice guidelines including people's safety and the promotion of people's dignity in order to provide a good quality service.

Staff we spoke with knew how to raise concerns or whistle blow and were able to explain the circumstances where they would raise concerns to ensure people's safety. However they had not recognised the need to

challenge or question some of their practices which were unsafe. This indicates a lack of understanding of the principles and values of good care both within the staff and management team.

Providers are required to notify us of accidents and incidents that occur at the home. The provider had sent us notifications as required. However whilst they had initially notified us of an accident that resulted in a fracture to a person they did not update us on the extent of the person's injuries once they had become aware of this sometime later. This would have enabled (CQC) to take follow up action where needed and ensure that the notification was an accurate account of the consequences of the accident that had occurred.

It is a legal requirement that the inspection rating is made available. We saw that the rating was displayed within the premises. This showed that the provider had met that legal requirement.

The provider was working with a number of agencies in order to rectify the shortfalls identified. They had also imposed their own restrictions on admissions until such time the service was safe.