Rockliffe Court Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 and 23 May 2018 and was unannounced on the first day. At the last inspection in October 2015, the provider received an overall rating of Good.

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

Rockliffe House supports up to 35 older people, some of whom may have sight impairment or be living with dementia. Communal rooms consist of a lounge, a dining room and a conservatory. There is also a small seated area in a walkthrough space near patio doors, which lead out to the garden and an area for people to smoke. Bedrooms, bathrooms and toilets are located over two floors accessed by two passenger lifts. At the time of the inspection, there were 34 people living in Rockliffe House.

The service had a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection, we had concerns about areas of the environment and equipment that required cleaning, tidying, repairing and in parts repainting. There were no cleaning schedules for day time domestic staff. Night care workers completed some cleaning tasks but there was no checking system to oversee work had been carried out by either day or night staff. The registered manager and provider were aware of areas in the environment that they wanted to improve; following the inspection, the provider told us these would be completed in the next six to twelve months.

There was a lack of understanding about the Mental Capacity Act 2005. This had impacted on the quality of capacity assessments and applications for deprivations of liberty. There were also shortfalls in the recording of best interest decisions and some people who used the service had signed documents when they were assessed as lacking capacity to understand them. Despite this, staff were clear they had to ask people for consent before carrying out care tasks and people who used the service told us they were able to make their own decisions and choices.

The quality assurance system was not effective in identifying shortfalls in the environment and other areas of service provision. The monitoring and analysis of accidents and incidents had not taken place since the member of staff allocated this task had left the service. This meant that lessons could not be learned in order to reduce accidents and incidents.

The provider and registered manager had not notified CQC of several incidents that affected the safety and welfare of people who used the service. This is a requirement of their registration.

The provider and registered manager had not completed a request for information called a 'Provider Information Return'. This would have assisted us in planning the inspection. We also noted some policies and procedures and documents were in need of updating.

These issues were breaches of regulations and you can see what action we have told the provider to take at the back of the full version of this report.

Staff knew how to safeguard people from the risk of harm and abuse. There was an inconsistency in how management dealt with incidents that occurred between people who used the service. Sometimes these were referred to the local safeguarding team but we found several instances when they had not contacted the team for advice and to make them aware of incidents.

People had assessments and care plans produced which helped to guide staff when they supported them. The assessments included areas of risk and were held with the care plans so staff could locate them quickly. Some risk assessments for health-related issues could have more information about the signs and symptoms of concerns. The registered manager told us they would address this.

People's health care needs were met and we saw they had access to a range of health care professionals when required. People were able to remain in the service if their health deteriorated and they needed end of life care.

The menus were varied and provided choices for people. Those people we spoke with told us they liked the meals and had sufficient to eat and drink throughout the day and night.

There were activities arranged for people and staff were designated an activity co-ordinator role each day.

People told us they liked the staff team and they had a caring and respectful approach. Staff were recruited safely and deployed in sufficient numbers to meet people's needs. Staff reported they were busy in the evenings when care staff numbers dropped to three instead of four. However, a change in the rota was planned, which should help to address this.

Staff received training, supervision, appraisal and support. This helped them to develop their skills and knowledge in order to support people and meet their needs.

The provider had a complaints policy and procedure on display. People who used the service told us they felt able to raise concerns and they would be listened to.

Equipment used had been serviced and maintenance personnel were available to attend to repairs. The environment had been adjusted to meet people's different needs, for example with grab rails, non-slip cushioned flooring, signage and strategically placed chairs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were areas of the environment and equipment that required cleaning and tidying to make them safe.

People received their medicines as prescribed. Clearer directions were required for staff when some people were administered medicines as needed.

Staff knew how to safeguard people from the risk of abuse and intervened appropriately to support people. Better recording and discussion with the local safeguarding team would enhance people's protection.

Staff were recruited safely and in sufficient numbers to meet people's needs. A new rota system will address a perceived shortage in the evenings.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a lack of understanding about mental capacity legislation which had led to deprivation of liberty applications not authorised and limited recording of assessments and best interest decisions. Staff sought consent before carrying out care tasks.

People's health care needs were met. People had access to a range of community health care professionals when there were concerns about physical and mental health.

The menus provided people which a balanced diet and included choices and alternatives. People told us they liked the meals.

Staff had access to training, supervision and support to help them feel skilled and confident in meeting people's needs.

The environment was suitable for people's needs and adjustments had been made to accommodate them.

Is the service caring?

Good

The service was caring.

People were happy with the care and support they received from staff. The staff approach was kind and caring.

Staff promoted people's dignity and respected their privacy. They encouraged people to be as independent as possible.

Staff were aware of the importance of confidentiality. Personal information and records were stored securely.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs and care plans which helped staff to look after them in a person-centred way.

People participated in activities within the service and some people accessed local facilities in the community.

When people's health deteriorated, they were able to remain at the service for end of life care.

The provider had a complaints procedure and people told us they felt able to raise concerns knowing they would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered persons had not met their registration requirements and notified the Care Quality Commission of incidents that affected people's safety and wellbeing. A request for provider information had not been completed.

The quality assurance system was not effective in highlighting shortfalls so that areas could improve.

Staff, people who used the service and relatives told us the registered manager was approachable and they could raise issues of concern with them.

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Detailed findings

Background to this inspection

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

This inspection site visit was completed on 21 and 23 May 2018 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors on the first day and one inspector on the second day.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report. We checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Before to the inspection, we spoke with local authority safeguarding, contracts and commissioning teams, and also health commissioners about their views of the service.

During the inspection, we 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 observed how staff interacted with people who used the service throughout the day and at lunchtime. We spoke with seven people who used the service and three people who were visiting their relatives. We spoke with the registered manager, a senior care worker, three care workers (one of whom also completed activities), a chef, a domestic worker and the administrator. The administrator had a senior care worker background and also completed staff supervisions and appraisal. We received information from three health and social care professionals.

We looked at eight care files which belonged to people who used the service. We also looked at other important documentation relating to them such as medication administration records (MARs) for 26 people

and monitoring charts for food and fluid intake, weights and pressure relief. We looked at how the service used the Mental Capacity Act 2005. This was to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included 3 staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

There were issues with cleanliness and safety in some parts of the environment, especially the small kitchen used by staff to prepare drinks and snacks, and the seated area near the lounge. Staff stored their coats and handbags on the work surface and floor in one section of the small kitchen. The cupboard under the sink had a basket filled with stale water and items, and the shelves required cleaning. There were cleaning products accessible to people as the door to the kitchen was not always secure. The cutlery tray had food debris in amongst the knives and forks. In the fridge, food items with a limited shelf life were not labelled with the date of opening, so it was unclear whether they were safe to use; there were also three meals from the previous lunchtime and sandwiches from suppertime that required discarding.

The drinks trolley was stored just outside the kitchen. The area behind the drinks trolley was dirty and dusty; there was also plaster dust that had not been cleared away when a new socket had been fitted. The drinks trolley itself required cleaning and tidying as it was cluttered with items on the lower shelves such as a basket of hair brushes and a hair dryer.

The chairs in the seating area near the kitchen had breaks in the leather, caused by wear and tear and the cats scratching the fabric; this made them difficult to clean properly. The tables in this area also required cleaning and had ingrained food debris in the edges. There were odd slippers and a used plastic glove on the bottom shelf of a dresser, someone's glasses (unlabelled) on the top of the dresser, no bin liner and a pair of slippers (unlabelled) on a coffee table. The cat food tray required cleaning. Two of the four wheelchairs stored in a section of the lounge had missing foot plates and it was unclear who some of the walking frames belonged to as they were not labelled. There were other wheelchairs in people's bedroom that also did not have foot plates.

The light pull cords in toilets and bathrooms, the fan in the treatment room and some radiators required cleaning. The receptacle for used continence products in one of the toilets had no lid and required cleaning. There was a window pane in one person's bedroom door which had a large crack and required replacement.

There had been a roof leak to some ceiling areas, which were dry but stained and required repainting. There were also some small areas in a toilet and a bedroom where plaster had bubbled away from the wall and required re-plastering. The provider told us they would address these concerns straight away. When we checked on the second day of inspection, the small kitchen and seating area just outside it had been cleaned and tidied.

These issues were a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of the service and people's bedrooms were clean and tidy.

The provider had safeguarding policies and procedures and staff had completed training in how to safeguard people from abuse. In discussions with staff, they were able to describe the different types of

abuse, the signs and symptoms that would alert them to concerns and who to report them to. However, when looking through care records for two specific people, there were 12 incidents of physical or verbal assaults this year. Although staff had intervened appropriately in each case and supported the people to be safe, the procedure had not been followed and the incidents not discussed with the local safeguarding team. Despite a lack of management reporting of safeguarding incidents, staff documented in care notes when they occurred and were able to describe how they diverted people to de-escalate incidents. The Care Quality Commission (CQC) had also not been made aware of these incidents, which is highlighted in the well-led section. Not notifying agencies or seeking advice following all incidents between people who used the service meant the agencies were unable to monitor how incidents were being managed and to check people were safe. The registered manager told us they would put measures in place to ensure all incidents were recorded on designated forms, discussed with the senior management team as soon as possible after the event and discussed with the local safeguarding team for advice. We told the registered manager to send in the notifications of past incidents and we received these just after the inspection.

People had risk assessments in place, which included areas such as smoking, nutrition, moving and handling, falls, road safety and skin integrity. There were also risk assessments for people's health and mental health related needs such as diabetes, epilepsy, anxiety, disorientation and behaviours which could be challenging to other people. The risk assessments helped to guide staff in keeping people safe and minimising risk, although some health-related risk assessments could contain more information about signs and symptoms. This was mentioned to the registered manager to address.

Medicines were stored securely and staff recorded when they were received into the service and when administered to people; there were no gaps in administration. However, one person was prescribed a medicine on an 'as and when required' basis to help relieve distress and anxiety over a specific issue. The person's medication administration record (MAR) showed they had been receiving this three times a day. The person's daily notes did not reflect the need for the medicine three times a day, although there were instances recorded when they had anxious behaviour. Similarly, another person had been prescribed a sleeping tablet to be used 'sparingly and intermittently'; however, the person was administered this every night for nine nights in a row. The person's daily notes did not reflect the need for the medicine every night. The registered manager took action to discuss this with the two people's GPs for clearer directions and updated us with their instructions.

Other people were prescribed 'when required' (PRN) medicines or those that required staff to make decisions about dosage, for example, one or two each time. Protocols that were in place did not provide staff with sufficient information for them to be able to evaluate how or when these medicines should be administered. The senior care worker responsible for medicines told us they would make the protocols much clearer for staff.

Staff administered medicines to people in a kind and considerate way. We observed them ask people if they had any pain, they provided water or juice to take the tablets with and waited to ensure the medicine had been taken before signing the MAR. People told us they received their medicines on time. A relative said, "[Name] has a specific medication and it is taken regularly; his medicines are always on time."

There was a gap in staffing numbers between 5 and 10pm each day. During the day up until 5pm, there were four staff on duty, the registered manager and the administrator who had a senior care worker background and was available for advice and support when required. There was also an additional care worker allocated to provide activities five hours a day until 4pm. A large number of people who used the service had low level needs and were independent with personal care. However, staff told us they could be very busy during 5pm to 10pm when there were three care staff on duty. The registered manager told us they would address this.

We will monitor staffing levels and shift patterns following the inspection, as the registered manager told us there was a change to 12 hour shift patterns occurring soon.

People told us they were well looked after. Comments included, "I really like it here" and "They look after me well." Relatives said, "They feel safe and secure here", "There is always plenty of staff on", "[Name] is very well cared for; they feel very safe and very secure" and "My mum loves it here and is very well looked after." A health professional said, "Staff are very good at providing safe care."

Employment checks were carried out prior to staff starting work in the service. These included an application form to assess gaps in employment, references, a discussion and a Disclosure and Barring Service (DBS) check. The DBS helped providers to make safer recruitment decisions, as it included a criminal record check and assessment of the register excluding people from working with those at risk.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Care Quality Commission (CQC) is required by law to monitor the use of the Deprivation of Liberty Safeguards [DoLS]. This is legislation that protects people who are not able to consent to care and support and ensures that they are not unlawfully restricted of their freedom or liberty. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. Applications for DoLS had been made for a number of people but there was a lack of understanding about the DoLS criteria and capacity to consent. For example, two people were assessed as lacking capacity and DoLS applications had been made. However, both people went out into the community unaccompanied and we were told the DoLS was in case they needed to ensure they took their medicines. Both people were to have reviews to discuss care and support issues.

There was also a lack of understanding about the ability of people to give consent when they lacked capacity. For example, one person had a DoLS in place but they were asked to sign their care plan and consent for a medical intervention. Another person, who the registered manager told us lacked capacity, had signed to say they agreed to the restriction of cigarettes. Another person had a sensor beam in place which alerted staff when they moved about their bedroom. There was no mental capacity assessment and best interest decision-making in either of these instances to evidence consultation or that the decisions were made in their best interest and in the least restrictive way.

This was a breach of 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they would ensure they and other members of staff had an update in MCA training. Staff told us they asked people's consent before they delivered personal care and respected people's decisions and choices.

People had access to a range of community health care professionals and staff recorded when visits from them occurred and any instructions they gave. There had been occasions when three people had not attended for retinol screening appointments. The registered manager told us people had declined to attend but this had not been communicated to staff at the retinol screening clinic. People had attended their most recent appointment and the registered manager told us they would ensure decisions were recorded in future. They also confirmed that if people lacked capacity, any decline to attend or distress when attending would be discussed in a best interest meeting and documented.

People's health care needs were met, which was confirmed in discussions with them. They said, "The doctor

came to see me and the staff consulted the doctor about prescriptions; they offered chiropodist services" and "They ring the doctor for me when I need them." Relatives said, "They always arrange doctors or any professional if needed" and "Staff contacted the doctor and dietician when [Name] was unwell and not eating. The staff now keep a daily food diary and discuss their progress daily and weekly with us."

Health and social care professionals said, "Senior staff and other staff communicate their concerns well" and "The home does appear to be effective in meeting their needs." One professional described how the staff team had supported a person by monitoring their mental and physical health needs, which had been stable for several months.

People told us they liked the meals provided to them. The menus provided choices for people and alternatives if required. Comments included, "They are always offering choices for meals and would help me to eat if I wished", "The food is good and there are choices", "I think the food is marvellous", "There's plenty to eat and drink; we get offered six drinks a day and any in-between" and "The food is good and well-cooked; there are always two choices at mealtimes." Relatives commented, "All the meals are excellent; there is always choice on the menu."

People had care plans for nutritional needs and risk assessments were completed; people were weighed in line with the risk assessment. There had been occasions when referrals to dieticians had been completed and their advice followed.

The chef told us they received information about people's dietary needs, any allergies and likes/dislikes. They also spoke to people daily about the food provided. We observed this during the lunchtime experience when the chef gave out meals and checked people had enough to eat. They confirmed people who used the service were asked in meetings if they had any preferences for the menu and on occasions they had attended the meetings to talk to people about their views. The chef was knowledgeable about people's needs and special diets such as those for people with diabetes, soft diets and those who required meals to be fortified. There was fresh fruit available for people to help themselves and snacks in-between meals such as cakes, biscuits, milkshakes and yoghurts.

Staff confirmed they completed training and received supervision to enable them to discuss issues of concern or their development needs. The supervision records showed care staff received this every two months. Every six months, the supervision meeting coincided with an appraisal to assess staff development.

Training records showed staff had access to training that was considered essential by the provider. These included, safeguarding, first aid, moving and handling, fire safety, food hygiene, infection control, medication administration and health and safety. The administrator told us they alternated the mode of training each year for specific topics. For example, one year there would be practical first aid training and the following year this would be refreshed with watching a video. Staff completed both theory and practical moving and handling training each year. There was a training plan for the year in place.

Staff had also completed other training related to the needs of people who used the service. For example, a training session on mental health had been delivered to staff by an external facilitator. Staff had also completed training in sensory impairment and dementia care needs. The majority of care staff had completed a nationally recognised course in care at either level 2 or 3. Staff completed an induction and one member of staff told us they were about to start the Care Certificate, which was a nationally recognised set of standards to be completed by staff new to care settings.

The environment was suitable for people's needs and thoughts had been given to specific areas. There was

cushioned flooring in corridors with grab rails to assist mobility. There were grab rails and support handles in bathrooms and toilets and equipment to assist people with moving and handling needs. Seating had been set in spaces in corridors upstairs and downstairs so people could stop and rest or sit and chat to each other. There was appropriate signage in the service to remind people of directions and which doors were toilets. The lift was appropriate for people with sight impairment, as it had verbal instructions when the floor was reached. During the environment check, it was noted there was a build-up of people's belongings that required sorting out. The registered manager told us they would address this straight away with keyworkers.

Good

Is the service caring?

Our findings

People told us they liked the staff team, they were treated with kindness and respect, and staff promoted their independence. Comments included, "They are very kind and caring and let me do the things I can do independently", "The girls are very nice and I'm very happy here", "Very nice people and I get on with them all", "They help me to wash my hair and back and leave me to get on with it", "I just tell them I'm going for a lie down; they respect choices" and "The staff look after me and also give me my space."

Relatives were also complimentary about the staff team. They said, "They are very caring, kind and pleasant", "I can say that each and every one of the staff are kind, caring, helpful and pleasant", "The staff always have time for [Name] and all our family" and "I couldn't wish for more caring, kind and professional staff."

Health and social care professionals said, "The staff are friendly and I have not witnessed anything to suggest otherwise" and "When I have visited and from what I have observed, I would say the staff have promoted independence, privacy and dignity."

Staff had a good approach and we observed positive interactions between them and the people they cared for. Staff provided explanations before completing tasks such as moving and handling. They were chatty and friendly with people and it was clear they knew people and their relatives well. When people wanted things from their bedrooms, staff fetched it for them without any fuss. They were attentive to people's needs and spoke with them in a caring and kind way. One person said, "The staff are smashing and fetch me cups of tea."

The provider paid for people's individual television licences and provided toiletries for people; they recognised people had limited funds and used their finances to purchase other items.

In discussions with staff, they were clear about how they promoted people's privacy, dignity and independence. They spoke about knocking on bedroom doors and respecting people's right to privacy, the way they liked to have their bedroom, cultural differences and religious needs. The provider had a brief statement policy regarding inclusion and respecting people's diverse lifestyles but this could be improved and is discussed in the well-led section.

Staff supported people to be as independent as possible. Some people were independent and accessed the community unescorted whilst others were supported by staff. Staff confirmed the majority of people were independent with personal care tasks, but the supervised the process and assisted when required. They also described how one person liked to have their bedroom in a specific way, which was respected by staff.

Staff provided information to people. There were notice boards with news about activities and photographs of people when they joined in. These showed people having a good time. Menus were on display in an accessible format and people spoken with knew what was on offer for lunch.

There was information about advocacy services on display. People had used advocacy services in the past.

Staff were aware of the need to promote confidentiality and conversations about people's care needs or with professionals were discussed in private. Personal care records were held securely in the registered manager's office, medication records were in the treatment room and staff records in the administrator's office. Shift handover records and other small items of information relating to people who used the service were held on a shelf near the satellite kitchen; these were removed and placed in a secure location on the day of inspection.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs and provided activities for them to participate in. Comments included, "The staff always help when asked", "The staff have taken me out to the park and the circus" and "I'm not bored and go to a pub and the tandem group." One person described how staff helped them organise how they used tobacco so they had sufficient to last the week. They said, "This helps make it last."

Relatives were also happy with the care delivered to people. They said, "There are plenty of activities and days out", "The staff look after [Name] in an excellent way; the care is superb", "I was able to ask for extra support and they responded quickly", "We always feel consulted and involved" and "Staff have always responded to our needs."

Health professionals confirmed staff had been responsive to people's needs. Comments included, "They make sure all needs are met." One health and social care professional did state they raised an issue with staff about recognising a specific person's changing needs; this was resolved. They also described a situation when management had been very responsive in a crisis situation and supported a person to access the service quickly. Another social care professional described how staff had supported a person with contact with their family.

People had assessments of their needs prior to admission to the service. The assessments included preferences for care, food and fluid likes and dislikes, what goals they wanted to achieve and important 'others' in people's lives. The assessments provided information for care plans in order to guide staff in how to care for people.

Care plans covered a range of needs and risk assessments were linked to them. Care plans also referred to people's routines in the morning and at night, although these were brief. This was mentioned to the registered manager to address. Monthly checks of care plans were completed and any significant changes or input from professionals was recorded.

Staff had completed 'patient passports', which accompanied people into hospital and provided medical and nursing staff with an overview of their care needs, previous medical diagnoses and information about next of kin and GP. These were up to date and reflected people's needs.

The provider had an end of life policy and procedure, which referred to staff respecting people's religious and cultural beliefs when delivering care and ensuring their final wishes were adhered to as much as possible. The registered manager told us people were able to remain at Rockliffe Court for end of life care and staff liaised with district nurses and other health care professionals as required.

There was a member of the care staff team on the rota most days for the provision of activities. These included nail care, dominoes, bingo, quizzes, baking, crafts, reminiscence and movie afternoons. Entertainers visited the service and people had trips out to local shops, cafes and other venues. The provider

told us they paid for the outings to local venues. Some people told us they preferred not to join in activities and this was respected. One person said they liked to stay in their bedroom and watch television but staff told them when entertainers were visiting so they had the option of listening to them.

The provider had a complaints policy and procedure, which was on display in the service. This referred to management addressing complaints quickly and provided timescales for investigation and resolution. People told us they felt able to raise concerns and they would be listened to. Comments included, "If I had a complaint, I would go to the staff", "I would go to whoever is in charge", "I haven't got any complaints" and "I would tell [names of provider and registered manager], they would sort it definitely." Relatives also confirmed they would be listened to and issues resolved. There provider had not had any recent complaints. The registered manager told us they tried to make sure any concerns were dealt with quickly to avoid the need for people to complain in a formal way.

Requires Improvement

Is the service well-led?

Our findings

People who used the service and their relatives knew the first names of the registered manager and the provider's nominated individual, both of whom were directors of the service. People who used the service spoke about them both in a familiar way and it was clear they felt able to approach them with any issues. The nominated individual also worked shifts at the service and both they and the registered manager made themselves available to speak with people and their relatives. There were positive comments from a range of people about how personable management was. Relatives said, "I think it is very well-managed", "I think it [management] is excellent" and "Yes, I am very impressed with staff and the level of care delivered."

A health care professional stated the service was well organised and a social care professional commented management were prepared to learn and develop. Another social care professional stated, "The management team are lovely and seem to really care." However, they also commented they had to push to ensure medical checks were completed for one person.

We had some concerns regarding the overall management of the service. The registered manager and provider had failed to notify the Care Quality Commission (CQC) regarding several incidents that affected the welfare of people who used the service. These related to safeguarding incidents which had occurred between people who used the service. There were also occasions when one person was missing from the service and had to be returned by the police.

Failure to notify us was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are considering our regulatory response.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report and it has impacted on the Requires Improvement rating for this key question. The registered manager told us they had not received the request for the PIR. However, the provider had received the request for the PIR. The registered manager told us they would notify the CQC of any changes regarding their email address so records could be updated.

Some of the provider's policies and procedures and documentation required updating, for example guidance for staff on managing complaints referred to CQC's predecessor organisation and had the wrong email address on it. The complaints policy and procedure for people who used the service or their relatives omitted information about other agencies such as the local authority or the local government ombudsman for escalation of complaints. The policy and procedure on equality, diversity and human rights was a statement of intent to include people rather than a procedure to guide staff in how to support people with diverse needs. The provider's statement of purpose, provided to us on the day of inspection, had not been updated to include additional beds registered in October 2017; it also referred to old legislation and standards.

There was a quality monitoring system in place which consisted of audits, surveys and meetings. Audits included medication, care plans, hospital appointments, people's food likes and dislikes, safeguarding and staff supervision. The audits were not effective; they failed to identify issues with the environment, out of date first aid supplies, lack of notifications to CQC and the safeguarding team, and people missing retinol screening appointments. There were cleaning schedules for night staff but no checking system to ensure tasks had been completed. There was limited guidance on cleaning tasks for the main domestic staff on duty during the day.

During the inspection, it was identified that accidents and incidents had been analysed during 2017. However, when the member of staff responsible for this task left, it was not reallocated. As a result, there was no analysis of accidents and incidents since December 2017. This meant the registered manager was unable to learn or put measures in place to improve people's safety. The registered manager was unaware of this and advised they would re-allocate this task to another member of staff. Staff had not completed incident forms but recorded in daily notes instead. This meant there was the potential for this information to be overlooked amongst the daily care interventions staff carried out with people.

The registered manager was unable to demonstrate how they kept themselves up to date with best practice guidance.

These issues were a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance personnel completed a check of the environment for any repairs or concerns. The registered manager recognised areas of the environment could be improved and planned to complete improvement works within the next six to twelve months.

In 2017, surveys were completed by people who use the service, their families, professionals and staff. Surveys were analysed and issues identified were addressed during residents and family meetings and staff meetings. Since the last inspection, there was evidence of regular residents and staff meetings.

Staff told us the registered manager was supportive and approachable. They also said they felt communication systems were in place which included shift handovers and a daily diary system for seniors to use. Comments about management included, "Yes, I feel well-supported", "Management is not too bad; they are easy going and listen to you", "Sometimes we have conflicting instructions, but they do listen when we point this out" and "If I have ever raised concerns they have been dealt with well; I raise things with [Names of registered manager and name of administrator]." The registered manager spoke of including people who used the service, having an open approach and an acknowledgement of people's diverse needs. They said, "It is a multi-cultural home and we don't discriminate. It is the resident's home and that is what we remember."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Care Quality Commission without delay of incidents which affected the safety and welfare of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons had a lack of understanding about the Mental Capacity Act 2005 and Deprivation of Liberty Safegaurds (DoLS). Inappropriate DoLS had been submitted and recording of capacity assessments and best interest decisions were not always in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons had not ensured areas of the service and some equipment was clean and suitable for use.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not ensured there was an effective system to assess, monitor and improve the quality and safety of the services

provided.