Abbey Grange Residential Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Abbey Grange is located in Hereford, Herefordshire. The service provides accommodation and personal care for up to 29 older people. On the day of our inspection, there were 23 people living at the home, some of whom were living with conditions such as dementia and Parkinson's disease.

The inspection took place on 9 and 16 of February 2017 and was unannounced.

There was a registered manager at this service, who was also the registered provider A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

People were not always protected from harm or abuse. Although the individual risks associated with people's care and support needs had been assessed, risk assessments were not always followed or understood by staff. This meant that people did not always receive safe care and support.

Incident and accident reports did not contain the detail needed in order to assess, identify and monitor risks to people. Where significant incidents had occurred, staff were not always aware of these.

Although staffing levels meant that people's physical needs were met, people's freedom was not promoted and people could not go out as much as they wanted to.

Referrals where made to a range of healthcare professionals, but medical guidance and recommendations were not always followed. People did not always benefit from a choice of different meals and drinks.

People were supported by a staff team who received ongoing training and support, but the training provided was not always reflective of the needs of the people living at the home.

Language and terminology used in people's care records was not consistently respectful or appropriate.

People were not able to pursue their individual hobbies and interests. Where group activities were available for people, these were only in the afternoons, which meant that people felt bored in the mornings before the sessions started.

The provider had not notified the Care Quality Commission or the local authority of safeguarding concerns, injuries sustained by people, or incidents involving the police.

The provider had not identified concerns and issues highlighted during the course of our inspection. They did not have oversight of the day-to-day running of the home, or information recorded in people's care

plans and risk assessments.

Staff were reluctant to notify the provider of accidents and incidents, or concerns about or changes to people's health and wellbeing.

People received their medicines safely and as prescribed. People had access to a range of healthcare professionals as and when required.

People enjoyed positive and caring relationships with the staff. People's individual communication needs were known and met by staff. People had been involved in discussions about what dignity and respect meant to them and how they wanted to be treated.

Where group activities were in place, people enjoyed these and looked forward to them. People's feedback and views were sought and there was a system for capturing and acting on complaints.

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 is not always safe.

Where individual risk assessments were in place to inform staff how to keep people safe, these were not always followed. People's freedom was not promoted and there were not enough staff on duty to take people out when they wanted.

People received their medicines safely and as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Although people had access to a range of health professionals, medical guidance and recommendations were not always followed.

People were not always offered choices with their meals and drinks.

Staff received ongoing training and support, but the training provided was not always specific to the needs of the people living at the home.

People were supported by staff who understood the requirements of the Mental Capacity Act and the importance of this to their practice.

Is the service caring?

Requires Improvement

The service was not always caring.

People's wishes and opinions were not always considered.

People and relatives had been asked what dignity and respect meant to them, and this information had been used to inform and improve practice.

People's individual communication needs and preferences were

known by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not always enjoy their individual hobbies and interests. Where group social activities were in place, these were in the afternoons only.

People's feedback was captured and acted upon. There was a system in place for responding to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not informed the Care Quality Commission of incidents and accidents affecting people living at the home.

Staff felt there was a 'blame culture', which made them reluctant to report incidents or concerns to the provider.

The provider had not identified the concerns highlighted during the course of our inspection.

The manager had established links with the local community for the benefit of people living at the home.

Abbey Grange Residential Home

Detailed findings

Background to this inspection

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

We made an unannounced inspection on 9 and 16 February 2017. The inspection team consisted of two Inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had knowledge and experience of residential care for older people.

We looked at the information we held about the service and the provider. We asked the local authority if they had any information to share with us about the care provided by the service.

We spoke with nine people who use the service, and five relatives. We spoke with the provider, who was also the registered manager, the manager and the deputy manager. Our inspection also included discussions with four members of care staff, the activities therapist and one healthcare professional. We looked at three care records, which included risk assessments, initial assessments of needs, healthcare information and capacity assessments. We looked at the medication administration records, three staff pre-employment checks, accident and incident forms and falls audits.

Requires Improvement

Is the service safe?

Our findings

We looked at how the provider assessed and managed the risks to the health and safety of people living at Abbey Grange. Prior to our inspection, we received information of concern regarding a person who had left the home during the evening, unaccompanied, and went missing. The local authority's recent assessment of the person's needs stated, "[person's name] needs to be secure and safe as they may try to leave the home unaccompanied." The person's risk assessment specified that fire door alarms were to be kept on and for staff to respond to these.

Having looked into the concern about the missing person, we found that this person had gone missing the previous month. However, this had not been treated as an incident or a matter of concern. The only available information about the incident was in the person's notes, which were brief and simply stated that staff had noticed the person went missing and was later brought back to the home by a member of the public. There was no information about how long the person was missing for, how it had been possible for them to go out by themselves, or how they were once they had returned home. The person's risk assessment had not been updated after the incident, which meant that consideration had not been given to what measures needed to be put in place to ensure the person's safety.

We spoke with staff members about the incident. Some members of staff were unaware the incident had occurred as this information had not been shared. Staff members who did know about the incident told us the person had been missing between one hour and an hour and a half, but had returned home unharmed. Although staff we spoke with demonstrated an awareness of the different types of harm and abuse and their role in keeping people safe, they did not regard the incident as a safeguarding concern, which meant they had not notified the manager. The manager told us that had they been notified, they would have informed the local authority and re-assessed the person's safety needs to ensure these were met. The manager told us they would discuss the incident with staff and use it as an opportunity to ensure staff understood how to recognise different types of abuse and harm and how to report these.

We spoke with the provider about the incident, and their understanding of their role and responsibilities in relation to protecting people from harm and abuse. They told us they had turned a fire door alarm off prior to the incident, contrary to the person's risk assessment, and that was how the person had been able to leave without staff being aware. The provider explained to us that this had been an oversight and error on their part. They told us they believed the person had, "Only been gone for half an hour", and, as the person had been safely returned home, they had not regarded it as a safeguarding concern. The provider told us they had first been made aware of the incident two weeks' ago. Despite being aware of the incident and their responsibilities in relation to keeping people safe, the provider had not informed the local authority, nor the Care Quality Commission. We spoke with the provider about the need to ensure their person's safety, and the safety of other people living at the home.

Although there were individual risk assessments in place for areas such as mobility, these were not always followed. For example, one person was living with a condition which affected their mobility. Their risk assessment stated that when the person became breathless, staff were to offer the person their wheelchair

to assist them. We saw this person was experiencing difficulty in walking. Although a member of staff provided assistance, safe moving and handling techniques were not used. Additionally, the member of staff did not offer the person their wheelchair. We alerted the manager to this, who told us the member of staff should have offered the person their wheelchair. The member of staff also confirmed to us that the person had been breathless and that they should have supported the person differently and as per their risk assessment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We looked at whether there were sufficient staff on duty to keep people safe and promote their freedom. People and relatives told us they believed staffing levels were sufficient in terms of staff response time. One person told us, "I don't have to wait long at all when I need help." A relative we spoke with told us, "They take the time to listen to [person]; they have the staff to do that." Our observations during the course of our inspection showed us that people did not have to wait for staff assistance or support. However, people told us there were not enough staff to enable them to go out when they wanted. One person told us, "It's like being in jail." They told us they wanted to go out more and were unhappy that this was not possible. We spoke with the manager, who told us that there were not enough staff on duty to take this person, or other people, out, but they had been in contact with the person's relatives about arranging for them to take the person where they wanted to go. The provider had reviewed the staffing levels, but this was with the view of reducing them due to the fact there were six vacancies in the home; there were no plans to increase staffing levels to enable people to go out when they wanted.

We looked at how the provider recruited staff and we saw that staff were subject to checks with the Disclosure Barring Service ("DBS"), as well as reference checks from former employers. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care. The manager and staff told us that staff were not able to work with people unsupervised until these checks were completed. These checks helped the provider make sure that suitable people were employed and people who used the service were not placed at risk through its recruitment processes.

We looked at how people were supported to safely take their medicines. People told us they got their medicines when they should, including any 'as required' medicine. One person told us, "I never worry about that, I get everything I need and when I need it." One relative we spoke with told us how important it was their relative got their medicines at set times throughout the day, which they told us staff were aware of and made sure happened. Another relative we spoke with told us how pleased they were that the manager had recently arranged a medication review for their relative and there had been a change in the prescribed medicine as a result. Only senior staff were able to administer medicines. They had to undergo medicine training and competency checks. This was to ensure that only trained and competent staff assisted people with their medicines. We found that bi-weekly checks were carried out to ensure the medicines held for people tallied with their medication administration records. This was an additional check to ensure people received their medicines safely, and as prescribed.

Requires Improvement

Is the service effective?

Our findings

We looked at how people's health and wellbeing was maintained and whether people had access to a range of health professionals, as required. Although specialist input had been sought where there were concerns about people's health needs, professional and medical guidance was not always followed by staff. For example, one person had been referred to physiotherapy nearly two years' ago. The physiotherapist had recommended specific exercises for the person to be carried out on a regular basis, which included breathing exercises. We spoke with the person's relative, who told us, "[person] doesn't like the exercises, I know that, but I don't think staff are encouraging them to do them." Staff we spoke with were unfamiliar with the guidance in place. We spoke with the manager, who confirmed that the person had not been supported with the exercises since the guidance had been provided, and that staff did not know that the guidance was in place. The manager said this had been an oversight and that they would ensure that the person's needs were reviewed and professional guidance shared with staff.

We looked at people's healthcare information and found that people had access to a range of healthcare professionals and teams, including opticians, the Mental Health Team, specialist nurses, and doctors. One relative we spoke with told us their relative had recently had a chest complaint, and staff had been quick to ensure the person saw a doctor, We spoke with a member of the Mental Health Team, who told us staff regularly contacted them if they had any concerns or needed advice.

Staff told us they felt the training could be improved. For example, one member of staff told us the training was too generic and was not tailored to the needs of the people living at Abbey Grange. Other members of staff agreed, and told us that they felt training in areas such as Parkinson's disease and diabetes would be helpful, as they needed to understand the conditions better so they could meet the needs of the people with these conditions. One member of staff told us that whilst they had been trained in how to assist people with walking and moving, the training had not covered specific conditions and the impact they have on people's mobility. This was reflected in our observations, as we saw that staff did not always use safe moving and handling techniques. We spoke with the manager about this feedback, and they told us they would look into arranging this training. At the time of our inspection, six members of staff had been enrolled onto the Qualifications and Credit Framework (QCF). The QCF is a nationally recognised qualification which demonstrates staff can deliver health and social care to the required standard.

Staff told us about training they had received, which included end of life care, Mental Capacity Act and safeguarding. One member of staff told us they had been shown how to use hoists when they started. They also told us they had worked alongside experienced staff members for a few 'shadow shifts before they were able to work by themselves. These shifts included both day and evening shifts so they could learn how to support people effectively throughout the day.

We looked at the choices people were offered with food and drink, and whether they received the individual support they needed with eating and drinking. On the first day of our inspection, people only had a choice of one meal available at lunchtime. The manager told us that this was not commonplace, and that choices were usually offered. On the second day of our inspection, there were two choices for people . However,

there was one option for the evening meal. One person told us about their evening meal, "It wasn't very good at all- cheese salad with bread and butter. Who wants to eat salad when it is so cold outside?" Another person told us, "You just get what you're given and you grin and bear it." The person told us they wanted to have alcohol with their lunchtime and evening meals, but this was never offered. They told us that a can of beer a day was their "only hobby" and that having this would make life more "bearable." We asked staff whether alcohol was ever offered to people. They said it was not, but they were unsure as to why. We asked staff what options people had with their meals. One member of staff told us, "There are always two choices, but people have to ask if they want something different." We spoke with the manager, who told us that ongoing improvements were being made to the choices offered to people with their meals. For example, people now had the option of a cooked breakfast one day a week as this was something people had requested. People told us they were happy with the quantity of food provided and that it was always home-made.

We saw that people received the individual assistance they needed during the lunchtime and evening meals, and that people were not rushed with their meals. Although no-one living at Abbey Grange needed additional assistance such as referrals to Speech and Language Therapy (SaLT) or dieticians, the manager was aware of when referrals should be made to SaLT . People's weights were monitored and reviewed on a monthly basis to ascertain whether anyone was at risk of malnutrition. The manager had recently introduced a system which meant that where there was a 5% decrease in a person's weight, a GP referral should be considered to look at the reasons for the weight loss and to reduce the risk of malnutrition by implementing measures such as fortified diets or supplements, where necessary.

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 provider was working within the principles of the MCA.

We looked at how the requirements of the MCA were implemented. Staff we spoke with had an understanding of the key principles of the Act and the effect on their daily practice. Staff and the manager told us that monthly one- to- one meetings were used to discuss the five key principles of the Act and to ensure that staff continued to think about the Act in their roles. One member of staff gave an example of a person who enjoyed smoking. They told us that staff did not encourage this, as it was bad for the person's health, but respected their right to do so and did not prevent them from having cigarettes when they wanted them.

Where people lacked capacity to make specific decisions, the manager had ensured they had access to an Independent Mental Capacity Advocate (IMCA). An IMCA is someone who helps people with communication difficulties make their views known and represents people when decisions are being made about them. Additionally, where people lacked capacity to make certain decisions, meetings were held with the person, as well as relatives and health professionals where applicable, to ensure staff acted in that person's best interests.

At the time of our inspection, people living at Abbey Grange had been assessed in respect of their individual

care and support needs, and the manager had ensured DoLS applications had been submitted accordingly. We reviewed a sample of these applications and saw that each application was specific to individuals' requirements. Where conditions were in place as part of the DoLS authorisiations, these had been complied with. For example, one person's DoLS conditions stated that a specific care plan must be put in place, which the manager had completed. Staff were able to explain to us why DoLS were in place for individuals.

Requires Improvement

Is the service caring?

Our findings

We looked at how people were involved in decisions about their care and support, and whether their wishes and preferences were respected. Whilst we saw that people's preferences were accommodated as much as possible in areas such as the gender of staff assisting with personal care, their opinions and views were not always valued. For example, people told us how much they enjoyed a monthly karaoke session. One person told us, "It's a real highlight for me!" The deputy manager told us how important the monthly sessions were. They told us, "It breaks up the monotony for people." The manager told us the karaoke was currently funded through the residents' welfare fund, and that the karaoke would have to finish in March as there would be insufficient funds. We spoke with the provider about the popularity of the session. The provider told us they already employed an activities coordinator and an activities therapist and therefore, were unwilling to pay for the karaoke, despite being aware its popularity and importance to people. After discussing the matter with us and the manager, the provider told us they would look into the possibility of finding funds to keep the karaoke session in place.

People and relatives we spoke with were positive about the care people received. One person we spoke with told us, "They (staff) look after me; they're very kind to me." A relative we spoke with told us, "They take good care of people, but in a relaxed and non-clinical manner." Another relative told us, "I believe the care is exceptional, I don't know what I would do without them." Our observations throughout the inspection showed us that staff knew people well and that people were relaxed and comfortable with the staff. One member of staff told us, "I love spending time with them (people living in the home). I make time for them as well, Everyone here has their own personality and little quirks and we don't try and take that away from them."

Staff told us about the importance of treating people with dignity and respect, and maintaining as much of their independence as possible. One member of staff told us one person enjoyed cleaning the home, so staff helped them do this. Another member of staff told us, "To me, dignity and respect is a lot about your tone of voice. We shouldn't ever patronise people." There was a 'Dignity Champion' in place, whose role was to challenge any practice which did not uphold people's dignity and respect.

Recently, the manager had arranged a 'Digni-tea' coffee morning for people and relatives, They had been asked what dignity and respect meant to them, and created a 'Digni-tree', which set out how people wanted to be treated by staff. We spoke with a relative about this, who told us, "Even though [relative] chooses to stay in their room, staff still make the effort to make sure [relative] has their hair done and their face creams applied. I think that is really important."

People's care plans recorded information about individual communication needs and styles. For example, one person's care plan documented that the person needed to be approached calmly and softly, and that the use of a loud voice would upset them. Although staff we spoke with told us they did not always have time to read people's care plans, they demonstrated an awareness to us of people's individual communication needs and how to meet those. At the time of our inspection, no-one living at Abbey Grange used the advocacy service to support them with decision-making and ensure their opinions were heard, but

the manager told us referrals would be made as and when required.

Requires Improvement

Is the service responsive?

Our findings

We looked at whether people were able to enjoy their individual hobbies and interests. One person told us, "No one has asked me what I like doing. I sit and watch the television, that's about it." We looked at this person's care plan, and it detailed the person's interests and what they enjoyed doing. We spoke with staff about the person's interests, but not all staff we spoke with knew about these. We spoke with the manager about this and about ways of ensuring people could enjoy their hobbies and interests. The manager told us more consideration would be given to people's individual social and leisure opportunities. They told us that this had started to improve, and gave an example of celebrating a milestone with a person recently to mark the occasion. We saw this was detailed in the recent newsletter, which was for people and their relatives.

Although group activities happened throughout the week for people, these always took place in the afternoons. We saw that this meant that people were sitting in the main lounge area from breakfast time until 2pm. One person told us, "It does get a bit boring at times." We spoke with the activities therapist, who told us it would benefit people if sessions varied between mornings and afternoon, to help prevent boredom for people. We spoke with the provider about this, who told us they would look into the possibility of morning and afternoon sessions.

The activities therapist told us that, as much as possible, they also tried to provide people with one-to-one sessions. For example, they had done some relaxation techniques with one person last week, which the person had enjoyed.The manager and activities therapist also told us about the importance of one-to-one time with people who chose to spend their time in their bedrooms, to help prevent social isolation. The manager told us that people's care plans would be used to identify further one-to-one sessions for people, which would be focused around their individual likes and preferences. For example, we discussed how one person's care plan detailed a sport team a person supported and how this information could be used by staff, such as discussing the team with the person and arranging for them to watch them,

We considered how people's changing needs were responded to. Relatives we spoke with told us that staff were quick to detect if there were changes in people's health and wellbeing. A relative we spoke with told us, " They know [person] well enough to know when they are unwell." One member of staff told us how staff had noticed a person's anxiety levels had increased, which had been discussed with the deputy manager and manager and a review held with the Mental Health Team. Handovers took place daily. A handover is a short meeting between staff who are finishing their shift, and staff who are beginning theirs. These meetings were used to share information about any changes in people's health and wellbeing.

We looked at how people's suggestions, comments and feedback were captured, and whether there was a system in place for dealing with complaints. Residents' meetings were held on a quarterly basis as a way of obtaining people's views. We saw people had been asked their opinion on matters such as activities, food and their general satisfaction with the care they received. Although there was a complaints procedure in place, this was kept in the office and was not accessible to people. We asked for the complaints procedure to be made visible and clear for people and relatives. The manager subsequently displayed the complaints procedure in the hallway for people. At the time of our inspection, no formal complaints had been received.

A relative we spoke with told us that action was taken when any concerns were raised. They told us, "If I had any concerns, I'd speak to the manager; they do respond. I know this because a few minor things have happened. Nothing bad, but it was sorted out!"

Inadequate

Is the service well-led?

Our findings

During the course of our inspection, we identified that the provider had not told the Care Quality Commission about safeguarding concerns or accidents and injuries sustained by people they support, as they were required to do under their registration with us. Only two statutory notifications had been submitted to the Care Quality Commission in the last 12 months, but we identified a recent safeguarding concern we had not been informed of, and in excess of fifteen accidents and injuries. We had also not been informed of two incidents which had resulted in the police being called. Statutory notifications ensure that the Care Quality Commission is aware of important events and play a key role in our ongoing monitoring of services.

We brought this to the attention of the provider, who told us they were aware of the requirement to submit notifications to the Care Quality Commission and that they accepted they were at fault for not doing so.

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

At the time of our inspection, the registered provider was also the registered manager. They told us their intention was to de-register, and for the manager to become the registered manager. We asked the provider how often they were at the home. They told us it was currently once a week, and would reduce to once a fortnight. We asked the provider whether they felt a weekly presence in the home was enough for them to fulfil their current requirements as registered manager and maintain oversight of the home. Whilst the provider told us it was sufficient, and that they wanted to give the manager time to develop in their role, we found they had not identified issues we discovered during the course of our inspection. For example, the provider was not familiar with people's care plans and how their needs were managed. They told us, "I don't have time to read people's care plans." We also raised concerns about how risks were managed, and the way in which accidents and incidents were recorded and reviewed. The provider told us, "I am not here."

We looked at how incidents and accidents were reported and analysed. Where incidents and accidents had been reported, the lack of detail meant that it was unclear what action had been taken to keep people safe. For example, one person had fallen and sustained a head injury. The accident form reported this and that the paramedics had been called as the person's head was bleeding. No other details were included, such as how the person had fallen and whether they had received medical treatment. We asked the provider about the incident. They told us they would expect more information to be recorded, but that the rest of the information would be in the person's daily notes. Although this information was later found in the notes, it was not readily available.

We spoke with staff about people's risk of falling. Their responses demonstrated to us that information about accidents and incidents was not being shared, nor was information about how to keep people safe. For example, one member of staff told us, "I was told that [person's name] had a bruise, but not how they had got the bruise." Another person's risk assessment stated they had not experienced a fall for nearly two years. However, this information was out of date as we saw later incident forms which stated the person had fallen since that date. We asked the manager to review the person's risk assessment in conjunction with the

incident forms and ensure that all staff were aware of the accurate position regarding the falls risk.

The manager told us a new system would be introduced, which would mean that risks to people could easily be identified. We saw the new reporting system, and found that it now looked at factors such as the surface on which a person fell, whether a walking aid had been used at the time of the fall and what condition it was in, and any warning signs before the fall, such as dizziness or faintness.

At the time of our inspection, there had been 11 falls in the previous month, and seven falls so far that month. Although the manager was carrying out falls audits, it was not clear from these what investigations had taken place, or the action taken to reduce the likelihood of falls for people. Additionally, the audits were taking place every three months. We suggested that in light of the amount of falls, audits needed to be done on a monthly basis, which the manager agreed with. After the first day of our inspection, the manager showed us a new falls recording system they had introduced, which included updating people's mobility risk assessments, making referrals to health professionals and creating individual falls actions plans, where applicable, to look at triggers and reduce the likelihood of further falls. Although steps were taken to ensure people's safety needs were taken once we had highlighted the risks, the provider had not identified this themselves, nor taken steps to ensure people's safety.

Staff told us that their morale had been low and that they did not feel able to approach the provider about incidents which had occurred, or raise concerns with them about people's health and wellbeing. One member of staff told us, "It is blame, blame, blame." Another member of staff told us, "If there is a fall, the first thing [provider] does is look at who was on duty when it happened. Staff are then told it was their fault." Other staff members told us they had informed the provider of someone's weight loss, and had been told that the person's weight had been stable when the provider had worked at the home full-time. Staff told us they felt criticised and blamed by the provider, which made them reluctant to report concerns.

We spoke with the provider about these concerns. They told us that they had a duty to investigate incidents, such as falls, and part of that was identifying any additional training needed for staff. They gave us a recent example of a former member of staff and told us a lot of falls had happened during their shifts and so additional support had been provided before the member of staff had left. However, we could also see that there had been a high instance of falls both before and after the staff member had worked at the home, which demonstrated the falls could not be attributed to one staff member. We agreed that investigations must take place, but all factors must be considered, not just which members of staff were on duty at the time. We explained our concern was that matters were not being reported because staff did not feel comfortable or supported in doing so. The provider told us they did not wish for staff to feel there was a 'blame culture' at the home, and would speak to them in the next staff meeting and assure them that was not the case.

During the course of our inspection, we raised concerns with the provider about some of the language and terminology they had used in records about people's care. The language used was not always respectful, and included terms such as people "defying" staff and "attention seeking." The provider told us the language and terminology used was "factual" and therefore, there was nothing inappropriate about the wording used. We explained it was still possible to report factually on a situation, without using that terminology. The provider acknowledged this, and said more consideration would be given to wording in the future. This is of particular importance as the provider and registered manager plays a key role in creating the culture of a home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with were positive about the manager and the way they ran the home. One person we spoke with told us, "[Manager] is here a lot. Always has a smile. They make time for me." One relative we spoke with told us, "[manager's name] knows what they are doing. They ask us for our views and feedback." Relatives also told us they knew who the provider was and that they saw them at events such as the summer barbeque held for people and relatives and cheese and wine evenings, as well as seeing them at the home. Relatives had been informed of the changes to the management structure.

The manager told us about some of the initiatives they had introduced since they came to post in November 2016. They told us their focus had been on improving staff morale. This included the introduction of an "Employee of the Month" scheme, in which people, staff and relatives could nominate staff members. The manager told us, "We have a dedicated staff team, we are very lucky, and I want them to know that."

The manager had started to establish links with the local community for the benefit of people living at the home. For example, in a residents' meeting, people had asked to plant bulbs. The manager had been in contact with a local college about setting up a gardening project. The manager had also contacted a local social club a person wanted to join, and had arranged for the person's relatives to take them to this.

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 provider had not notified the Care Quality Commission, nor the Local Authority, of safeguarding concerns and injuries sustained by people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Although people's safety needs had been assessed, their risk assessments were not always followed. This placed people at risk of harm or abuse.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Incidents and accidents were not always recorded, analysed or shared with the staff team. Staff felt unable to inform the registered provider about accidents and incidents due to the fear of being blamed.

The enforcement action we took:

Warning notice.