Helme Hall Limited

Living Well Street and Tom Wroe Unit

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 4 July 2018 and was unannounced. At the last inspection the service was rated Good. We inspected this service because we received information giving us concerns about the safety and quality of care. This was a comprehensive inspection.

Living Well Street and Tom Wroe Unit is registered to provide residential care for up to 46 people, some of whom live with dementia. Accommodation is split in to three units, one on each floor of Helme Hall. These are separately called Tom Wroe Unit, Huddersfield Adult Memory Disorders Unit (HAMDU) and Living Well Street. Each floor has separate bathrooms and toilets and communal areas. At the time of the inspection there were a total of 17 people living there. There is a manager based on each unit with an overall manager for the whole service.

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

There was a registered manager for the service. There were plans for the registered manager to move to manage a separate part of the service. At the time of the inspection the new manager of Living Well Street and Tom Wroe Unit (who had been in post for four weeks) was not the registered manager but had made an application to be the registered manager. This manager was available throughout our inspection.

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

People and their relatives told us they felt safe living at this service as they were well supported and their health care needs were met. Staff had received safeguarding training and knew how to identify and report signs of abuse.

Recruitment practices were thorough to ensure staff had the suitable characteristics and background to provide care at this service. At the time of the inspection there were sufficient numbers of suitably qualified and competent staff to meet the care needs of people living at the home. However, there had been a high staff turnover prior to the inspection and the registered provider had not ensured there were enough sufficiently trained staff to support people during this time. This meant the provider had failed to plan effectively to ensure effective governance systems were in place. You can see what action we told the provider to take at the back of the full version of the report.

Audits had not identified concerns regarding the storage and administration of medicines. Medicines were not consistently stored safely. A medicine delivery had been left in an unlocked room where a person living

at the home found them. Medicines were not administered consistently throughout the home. One unit recorded the application of topical creams on a body map however the two other units did not do this. This meant the provider did not have appropriate systems in place to identify concerns with the administration and storage of medicine. You can see what action we told the provider to take at the back of the full version of the report

The registered provider had recently appointed a workforce development manager and comprehensive training was completed in-house. We saw evidence of staff supervision and appraisals being completed.

People's dietary needs were well managed and there was a good choice of home-prepared food and snacks. Some of the people were supported to buy and prepare their own food. This meant staff were able to accommodate people's individual preferences.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. It was evident from our discussions with staff they had an in-depth knowledge of people's care and support needs.

Care plans were person-centred and focused on a therapy-led model of care. A clinical nurse (specialist care) had been employed to support the care staff to provide safe and effective care for people and ensure people received individualised support with minimal restrictions. Staff respected people's privacy and dignity as well as their equality, diversity and human rights.

Not all care plans had appropriate capacity assessments, consent or authorisation to give consent where the person was unable to do so. This meant consent to care and treatment was not always sought in line with legislation and guidance. This was brought to the attention of the manager who confirmed they would review all capacity assessments. We have made a recommendation about reviewing people's capacity to support consent and choice.

Effective quality assurance systems had not taken place. The registered provider had failed to ensure appropriate risk assessments had taken place for fire safety and for the refurbishment of the premises. Accidents and incidents were recorded and although there were plans to ensure monitoring of these took place, appropriate monitoring had not always taken place. This meant the provider did not have appropriate oversight to ensure governance systems were adequate to ensure people's safety. You can see what action we told the provider to take at the back of the full version of the report. Plans had been made to ensure this was done in the future.

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.

People did not always feel they were protected from other people living at the home. Risk to people's safety was not always managed and monitored.

High staff turnover had resulted in a lack of sufficient number of suitable staff to support people's needs.

Medicine administration was not consistent throughout the home.

Procedures were in place to protect people from infection.

Is the service effective?

Good

The service was Effective.

People's needs and choices were assessed and care, support and treatment was provided in line with guidance and consent had been sought.

Staff were trained and had the knowledge and skills to deliver effective care and support.

People were supported to eat and drink, where appropriate, and had access to support to maintain a balanced diet.

People were consulted on how they wanted the service to support them and in recent refurbishment plans.

Is the service caring?

Good

The service was Caring.

People were treated with kindness, respect and compassion.

Staff were caring in their interactions with people. People's privacy and dignity were respected.

People were supported to be independent and staff encouraged

them to do so.

Is the service responsive?

Good

The service was Responsive.

People received personalised care and support based on their likes, dislikes and choices.

People and relatives were encouraged to voice their opinions and concerns and complaints were dealt with in line with policies.

Is the service well-led?

Requires Improvement

The service was not consistently Well-Led.

There was a clear vision and strategy in place; this supported and promoted a positive culture of person-centred care.

The governance framework did not support quality performance and risk management. The service did not have systems to continuously learn and improve

People who live at the home and their relatives were engaged and involved in the service.

Living Well Street and Tom Wroe Unit

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 registered 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 took place on 4 July 2018 and was unannounced. Prior to the inspection we had received anonymous concerns relating to the management of the service and the safety of the people living at the home. This inspection was in response to the concerns raised. The inspection team comprised two adult social care inspectors.

Before our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. We contacted commissioners of the service, safeguarding and Healthwatch to find whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give some key information about the service, what the service does well, and improvements they plan to make.

During the inspection we spoke with two people who lived at the home and two relatives. We spoke with the operations manager, the manager, two unit managers, a senior night worker and two carers, the workforce development manager, and the clinical nurse specialist care.

We looked around the building and saw the communal kitchens, dining rooms, lounges and bathrooms and

a person showed us their bedroom. We spent time observing care in the communal lounge and dining areas to help us understand the experience of people using the service who could not express their views to us.

We reviewed a range of records which included four people's care files. We also inspected three staff members' recruitment and supervision documents, staff training records, and other records relating to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

People did not always feel protected from other people living at the home. We asked people if they felt safe and one person told us, "Yes, very safe." Another person said, "No, because I need to have my door locked. I can't go to the kitchen because [another person] kicks and swears." The unit manager suggested this was due to different personalities within the unit. We saw from incident logs one person had fallen while trying to get out of bed because they had been frightened by the noise from other people in the corridor during the night. There was no evidence an investigation had taken place as a result of this incident.

We asked staff whether people were safe living at the home; one said, "Oh, yes, they are, they're well looked after. [People] are all happy and smile when we come in." However, people told us staff did not always act on their concerns about their safety from other people living at the home. We discussed people feeling safe with the manager who confirmed they had identified these risks. They explained how people had been placed in each unit according to their diagnosis and their immediate plans to place people according to their needs and personalities. This would ensure people felt safe with other people living at the home.

Support workers we spoke with were able to describe the forms of abuse to which people living at the home might be vulnerable. They told us they would report any concerns to their line manager.

Risks associated with people's support needs were not always adequately assessed and recorded. We observed staff supporting people to move and found safe procedures were not always followed. On one occasion staff moved someone in a way which was not described in the person's care plan. We saw the person's care plan did not detail how staff should assess the person's ability to weight bear before supporting them to move as this person's ability varied. We concluded this was a breach of Regulation 12(2)(a) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the person's moving and handling needs had not been appropriately assessed or documented. We spoke with the manager about this who provided evidence showing the person was being reassessed for a new piece of equipment to help them move and arranged for the care plan to be updated.

We observed two staff supporting someone to move using a hoist, staff were knowledgeable about how to do this and how the person liked to be supported.

Staff were supported to be vigilant and act appropriately to positively manage people's behaviours which might challenge the service. We saw one person had a very detailed behaviour risk assessment that contained information about the first signs, 'build-up' behaviours, different type of possible behaviours, and after-episode behaviours that could occur. These are some of the terms used to understand, plan for, and support people's behaviour.

Prior to this inspection we were aware of an incident involving injuries sustained by a staff member. We explored the behavioural risks of people living at the service and how these were managed at the service and were satisfied these risks were well-managed. The service had employed a clinical nurse specialist care who had responsibility for managing and mitigating behavioural risks. We saw risk assessments in place

which managed these risks appropriately.

As part of our inspection we checked how the service was managing risks to people. We saw from people's care files the registered provider used standardised risk assessments, such as the Waterlow scale, and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults, who are malnourished, or at risk of malnutrition.

Fire evacuation procedures were not clear. We asked night staff what they would do in the event of a fire. A staff member said a designated person would check the alarm, and another would stay with people, the fire doors would close, and they would wait for the fire brigade to evacuate people. We asked day staff about fire procedures. A staff member said one person would stay on the unit, "We don't evacuate unless needed due to resident's needs." This was not in line with the providers own fire procedures or what the manager told us about their horizontal evacuation procedures. Horizontal evacuation procedures are where people are moved to a designated safe place within the building. This meant people were at risk in the event of a fire because fire evacuation procedures were unclear. We concluded this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure fire evacuation procedures were clear to all staff.

Simulated fire evacuations had not taken place however fire drills had been completed bi-annually. These had not been evaluated or lessons learnt shared with staff. Personal emergency evacuation plans were in place for people living at the home.

A fire audit had been completed by the Fire Service on 2 July 2018. This found the registered provider to be in breach of fire regulations. Since the inspection the registered provider has produced an action plan detailing how they would meet regulations and has already taken some actions in line with findings.We concluded this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems and processes were not monitored effectively.

Certificates we looked at showed gas safety and electrical wiring had been checked within relevant timescales. We also found lifting equipment had been thoroughly examined and relevant checks had been carried out in relation to other aspects of maintenance.

There had been high staff turnover within the service. We asked staff about current staffing levels and one person said, "Not brilliant at the moment, few people started and others left in the same week due to behaviours [of service users]." When we asked about the impact of this on people we were told, "No impact, we have got agency cover." We discussed staffing levels and how these would support an emergency evacuation procedure with the registered provider and manager. They explained they had a planned procedure in place and staffing levels were higher than the dependency needs of people living at the home. We were provided with evidence of how the provider assessed dependency and were assured staffing levels were now appropriate.

The manager explained how the service had some vacancies which were in the process of being recruited to. The manager told us how they made sure staffing rotas were co-ordinated across the service and were produced based on people's needs and the skills and personalities of the staff. This meant people received appropriate support.

We looked at the recruitment process for three members of staff and found this was safe. We saw evidence of application forms, detailed interview records which were scored and evidence of identity of the staff member having been checked. Background checks had been carried out through references and with the

Disclosure and Barring Service (DBS). The DBS assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

There was a lack of consistent oversight from managers about how medicines were administered. Medicines were administered differently on each unit which was not consistent with the company's medicines policy. For example, only one unit recorded the application of pain patches on a body map. We concluded this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as management audit systems had not identified inconsistencies in the medicine administration. The manager had recently identified this anomaly and had made plans to bring all medication procedures in line with national guidelines and company policy.

Correct medicine storage was not always followed; a medicine delivery had not been locked away. This had resulted in a person living at the home having access to someone else's medicine. The person had not taken any medicine and had not been harmed by this incident. Medicines were stored in a dedicated room which contained a fridge; both the room and fridge were monitored to ensure medicines were stored at the correct temperature. We checked the stock of medicines, including those of controlled drugs, and found these were correct. Records of these were checked twice daily by the unit manager. Controlled drugs are those covered by misuse of medicines legislation, and include medicines such as strong painkillers.

We saw staff checked people's medication administration record (MAR) before administering medicines and recorded the person had taken their medicines afterwards. Staff administered medicines from trolleys which they locked when leaving them unattended. We observed staff administered medicines to people in a caring and person-centred way, and made more than one attempt to administer medicines to people who either refused or were asleep. People were asked if they needed medicines prescribed 'when required', for example for pain, and care plans and detailed protocols were available to inform staff about how and when people needed these medicines.

All areas of the home were clean. Staff made good use of personal protective equipment such as gloves and aprons when undertaking personal care and changed these for each task. Staff showed good handwashing techniques. An infection control audit undertaken on 5 December 2017 scored the service 98%. This meant good infection prevention and control measures were in place.

The new manager had identified areas of improvement and lessons learnt from quality monitoring and discussed plans to improve these. For example, implementing a twice daily check for medicine administration. However the previous lack of management oversight of audits and performance management had meant that improvements and lessons learnt had not been identified or implemented.

The manager said, "I'm designing direct staff observations to include medication competencies so these will be done every two weeks." The manager had also identified a need for a standardised approach across the units to paperwork, explaining changes would be discussed at staff meetings and will be agreed by all. Following analysis of behavioural incidents in the units the manager had identified people would be better cared for by being placed in units according to their needs and personalities, they said, "We want to see what each individual engages with," rather than their diagnosis to enhance their person-centred care and support.

Good

Is the service effective?

Our findings

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

Staff had received MCA training and we observed people were supported by staff to make decisions throughout our visit. We found staff were knowledgeable about assessing people's mental capacity on a day by day basis and for different activities. One staff member said, "My approach is that they [people] have the capacity until they show otherwise; I look for ways that they understand; depending on the pressing nature of it [decision] I might come back at a different time, if not, I'll make a best interest decision for them."

Care plans included people's consent to care. Recent consent had been recorded about new data protection regulations. In one care plan we looked at this had been signed by a staff member. This should have been signed by the person or their advocate. We also found a relative had signed a consent form without the appropriate authorisation to do so. In another care file we saw a mental capacity assessment had been made about a person's lifestyle choice, but had not been undertaken for their medication. This meant consent to care and treatment was not always sought in line with legislation and guidance. This was brought to the attention of the manager who confirmed they would review all capacity assessments. We recommend that the service finds out more about capacity assessments and consent, based on current best practice, in relation to the specialist needs of people living at the home

A staff member gave an example of how one person was able to make a decision about their day-to-day money expenditure because they had a good understanding about basic calculations, change and consequences of spending the money.

Care plans showed how people's needs were assessed and support provided was appropriate to their needs. Observations and conversations with staff showed they were very knowledgeable about people and the individual care and support each person needed. One staff member was able to describe positive behaviour support to be provided to one person if they were displaying behaviours considered as challenging; some of the support included restraint. This was the same information that was on the person's care plan.

There had been several incidents where staff members and visitors had been subject to aggression by people living at the home. We asked one staff member that had been injured if they felt the support plans were appropriate for the behaviours displayed and if they felt safe, this staff member said, "Yes, I never felt in danger."

Records showed staff received annual training, where awareness was undertaken online and then delivered face to face by the registered provider's in-house workforce development manager. The workforce development manager also visited each unit regularly to allow staff to ask questions about certain aspects and receive practical support. This additional support was recorded along with all planned training.

People had a choice of food available at each meal time and had access to snacks and drinks throughout the day. On the Huddersfield Adult Memory Disorders Unit (HAMDU) people were supported to purchase their own food. Meals were prepared by staff in each unit. People were encouraged to eat independently where they were able and gentle encouragement was used. Where people were assisted to eat this was appropriate to each person with staff taking time to support people. For example, one person did not like to sit down to eat, so staff followed the person as they walked and provided small mouthfuls to them when they stood and showed they wished to eat. This was done with patience and care.

Detailed and thorough handovers took place at the start of every shift. Each staff member made their own notes on a pre-printed sheet which included the name of each person, any health details, the name of their GP, whether the person had showered or bathed, any bowel movements, and their fluid intake during the previous shift. This showed staff had a good understanding of people's lives.

We found unit managers worked together, supported each other and were knowledgeable about people living on each unit. This meant staff were deployed according to people's support needs.

One person showed us their bedroom. The person had been provided with an additional wardrobe for their clothes, which they liked. There were lots of family photographs on the wall and the person had a windowsill full of pot plants which they enjoyed caring for.

The service had undertaken recent refurbishment and had plans to undertake more. People had been consulted with and had made suggestions to the use of the rooms and how these were decorated, for example, asking for new pictures, small tables and an additional music player. On Living Well Street there was a sensory area for people to relax for periods during the day with sensory objects, lights and books to stimulate and entertain people.

We saw staff recorded detailed notes about people's lives and any changes in their mood, behaviour and health. This meant staff were able to identify when people needed additional support or professional help or assistance and we saw this was received promptly. For example, one person had variable mobility needs and a referral had been made to occupational therapists for a review of their needs.

Good

Is the service caring?

Our findings

During our inspection, we spent time observing the interactions between people and staff. People looked comfortable and relaxed when interacting with staff and staff maintained warm relationships with people. Staff smiled and made eye contact when talking to people and used gentle touches to engage them. Staff were patient when talking to people and gently used repetition to check people's understanding and reassure them. Staff chatted to people and asked people's permission before supporting them. They provided constant explanations about how they were supporting people.

Staff were able to describe people's individual preferences. One staff member said, "I know [person's name] likes chocolate so I always get them some." Another said, "[Person's name] likes clothes and shopping for shoes."

Staff we spoke with could explain the importance of protecting people's equality, diversity and human rights. The registered provider had arranged for a religious leader to visit the service on a monthly basis. We saw evidence of visits being made by people to other religious services to take part in religious festivals.

Access had been made to advocacy services where this was needed however people and their relatives were not always involved in reviewing people's care and support needs. The two people's care files we looked at in detail did not show how people and their relatives had been involved in setting up and reviewing their care. However, people were involved in their daily care and support particularly when their needs fluctuated, for example, being asked how they wished to be supported throughout the day and we observed staff being responsive to this.

We saw minutes from 'resident's meetings' showing people were asked for their views about how the home was run. One unit, Living Well Street, used flip charts to encourage people to participate and staff wrote down what people asked for, for example, 'What does summer mean? Ice-creams, salads instead of stews, sitting in the sun' and we saw evidence these had been incorporated into people's daily living.

We observed staff always knocked on people's doors before entering. We saw people's confidential and sensitive information were stored securely and not left unattended. Staff were discrete when administering medicines, for example, when asking people if they had pain, and when asking and supporting people to the toilet. We observed careful use when hoisting a person to make sure this was completed with dignity. Whilst administering liquid medication one staff member spilt a small drop on a person's shirt. The person was immediately supported to change into a clean shirt. This meant people's dignity was respected and promoted.

Good

Is the service responsive?

Our findings

One person told us, "I like shopping for clothes so I have two wardrobes." Another person said, "I like to bake but don't want to today," and we saw had staff made alternative arrangements to take that person out instead.
Care plans were detailed and person-centred and included their likes, dislikes and preferences in relation to physical, social and leisure activities. We observed how staff supported people to achieve these, for example, encouraging them to water the plants in their bedroom and supporting them in this activity. People were encouraged to suggest both individual and group activities and we saw how staff made sure everyone was included in discussions and had a voice by using a variety of communication methods suitable for everyone living at the home.

People had personalised activity planners which included items such as 'drive and visit to mum' or 'personal shop'. Activity planners had pictures explaining the activities and notices about activities on noticeboards included pictures. There were optional group activities within the home such as chair aerobics, gardening or baking. We observed two people spending time doing a word search after breakfast. People were relaxed and had access to newspapers. One person was playing dominoes with a support worker. People were supported and encouraged to walk outside throughout the day. People were supported to access the community and other units in within the service for some activities. Church choir groups also visited the home.

One person's personal profile had a section titled 'what makes me happy' and indicated, "[Person] likes smoking, walking around the grounds, going for rides in the car." This person's support plans explained how staff should support this person with being part of these activities and staff we spoke with described those same activities.

The home was compliant with the Accessible Information Standard by identifying, recording and meeting people's communication needs. Care plans recorded how people liked to be communicated with and throughout the home information for people was shown in different formats, for example, using pictorial cards.

Not all care plans we looked at showed involvement by people or their relatives in the reviews of their care and support needs. The manager had identified this and said the service were in the process of reviewing all people's support plans and to focus on involvement by people and their relatives in these.

The service had a complaints policy and kept records of compliments and complaints. Records showed complaints had been dealt with in timeframes specified in the complaints policy and investigations and lessons learnt had been well-documented. Numerous thank you cards were displayed in reception. The manager had identified occasional concerns raised by relatives when visiting were not captured because they were dealt with at the time, but planned to introduce a 'grumbles' log to capture and analyse these.

The manager explained how people and their relatives had been asked about their future wishes, in relation

to their end of life care, although most had declined. The care plans we looked at did not contain end of life plans. The manager explained most people and relatives felt uncomfortable considering any advanced planning, but planned to discuss how to approach these conversations with support from hospice professionals.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager for the service. There were plans for the registered manager to move to manage a separate part of the service. At the time of the inspection the new manager of Living Well Street and Tom Wroe Unit (who had been in post for four weeks) was not the registered manager but had made an application to be the registered manager. This manager was available throughout our inspection.

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

People we spoke with were able to tell us who the manager was even though the manager had only been in post for four weeks.

Feedback from staff regarding the management team included, "At the moment really well, a couple of months ago was rubbish, [name of unit manager] is great, like one of the staff." Another staff member said, "On the unit, management is very approachable; on the home I don't have much interaction, don't know who the registered manager is." Plans for absent managers and staff during high staff turnover had not been established and consistent leadership had not been in place which resulted in a lack of consistent governance. We concluded this was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and staff were able to articulate the vision for the service and had clarity about tasks needed to achieve this. There was a positive atmosphere throughout the service and staff spoke positively about managers. The manager explained, "I get support from the Chief Executive Officer, we have at least a weekly meeting and produce action plans to work from so everyone has an overview." Fortnightly senior management team meetings were taking place. Staff meetings were held monthly on each unit and a whole service meeting was held quarterly with very good attendance, however lessons learnt had not been identified or shared with staff.

We found staff also spoke positively about a culture of team working across the floors. We observed staff working well together throughout this inspection. One staff member said, "No problems with new staff. It's a nice place to work." Another said, "There is good rapport with staffing team." We found each of the floors was led by the respective unit managers; two of these were new managers and received support from more experienced managers.

Governance and performance management was not always reliable and effective. The recording of risks and issues, accidents, incidents and safeguarding took place in isolation on each unit. Systems were not reviewed in a joined-up manner as it had not previously been identified units were operating differently and these risks consequently had not been identified by management.

Quality assurance arrangements were not always applied consistently and potential improvements resulting from these not always identified. We shared with the registered provider, the commercial director and the manager the information we had found relating to people's safety. The management team were responsive to requests for information and the concerns raised during the inspection. They told us they would look into these issues and make the necessary changes immediately.

During the inspection we were made aware there had been a recent fire service audit and the provider has now been issued with an enforcement notice because of a breach in fire regulations; in particular about fire evacuation drills and provision of fire evacuation equipment. We have discussed with the provider the actions they are planning to take as a result of this.

We saw evidence of monthly 'residents' meetings'; standing agenda items included menus, activities and the living environment. People were also given the opportunity to feedback about the service through surveys. Following feedback, the registered provider had developed plans to include more community-based activities for people living at the home to support their independence.

Relatives and staff surveys were undertaken annually. Results from 2016 had been analysed and published. Results from 2017 had been published, but there was no evidence analysis had been undertaken. People ringing the service received an automated message encouraging them to provide feedback. Comments slips and a box for these were available in reception. There was no evidence that these were analysed.

We saw plans for further redecoration of the service, which included details about how these plans involved people living at the home. A mood board had been produced and people could point to which aspects they liked or add things they wanted to be included as part of the redecoration. A risk assessment was not in evidence for these plans.

The service had good links with the local community. People were encouraged to attend church services, if they would like, and the local vicar provides a service each month. The local school used the grounds and provided a choir at Christmas. Local schools attended open service open days. The service had plans to extend the use of the grounds to include community-involved gardening and involvement from the local donkey sanctuary.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Breach in fire service regulations relating to basement, storeroom, smoke alarm testing, combustible materials and doorguards. Fire evacuation procedures not clear to all staff. Risks associated with people's moving and handling were not always adequately assessed, recorded and followed. Medicines administered inconsistently between units. Medicines not locked away.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management systems did not identify breaches in fire service regulations, particularly regarding requirement to update risk assessment, fire tests and drills. Management systems did not identify risks from inconsistency of medicines administration. Plans for absent managers and staff during high staff turnover had not been established and consistent leadership had not been in place. Governance and performance management was not always reliable and effective. The recording of risks and issues, accidents, incidents and safeguarding took place in isolation on each unit. Systems were not always regularly reviewed as it had not previously been identified units were operating differently and these risks had not been identified by managers.