Mr David Hetherington Messenger

Epworth House Care Centre

Inspection report

Park Road
Thurnscoe
Rotherham
South Yorkshire
S63 0TG

Tel: 01709893094
Website: www.elderhomes.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out 26 July and 4 August 2016 and was unannounced on both days, which meant the provider and staff did not know we would be visiting. The service was last inspected in January 2016 at which time the service was not meeting the requirements of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a history of breaches of regulation. We checked to see if any improvements had been made with the breaches identified at the last inspection, which included, regulation 12 safe care and treatment, regulation 16 receiving and acting on complaints and regulation 17 good governance. The registered provider was placed into special measures in December 2015 by CQC. This inspection found there had still not been enough improvement to take the registered provider out of special measures. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Epworth House Care Centre is a care home registered to provide personal care and accommodation for up to 67 older people. The home is separated into two units. One unit is for people living with dementia and is sited on the first floor. The second unit is for people who have personal care needs with the main living accommodation sited downstairs. At the time of our inspection 38 people were living at the home.

There was no registered manager in post; however there was a manager who was responsible for the day to day running of the service, who told us it was their intention to register with CQC. 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 at the home, and they were satisfied with the care and support which was being given by the staff team.

Staff had received training and were able to demonstrate their knowledge and understanding of how to safeguard vulnerable adults. However, we found there had been a serious incident which had not been investigated thoroughly or in a timely manner.

We found there were updated personal emergency evacuation plans in place in all the care files we reviewed, which had been a concern at the previous inspection.

There were risk assessments in place for particular risks, however, we found these were not always correctly completed and information contained within them did not always match other records in the care file.

We looked at the management of medicines. We found there were still concerns with record keeping for

medicines, which were being administered within the service and the temperature at which medicines were stored was not always within the recommended range.

Recruitment records we looked at showed that there were some staff who had not had a recent disclosure and barring service check (DBS). We also found that previous employers had not always been contacted to gain references to ensure the good character of staff.

There was sufficient staff on duty to meet the needs of the people who used the service.

There had been a significant improvement in the training of staff, however we found there was an concern with how this had been recorded which meant it was not possible to identify whether training had been face to face or a booklet.

We found that whilst there had been applications made for Deprivation of Liberty Safeguards (DoLS) to be authorised, the records were disorganised and there was no clear record of who required a DoLS, when the application had been made, if the DoLS had been authorised or when the provider needed to apply to renew the DoLS.

We found there was very little evidence of the provider seeking consent to care from people who used the service. We found clear evidence that consent was being signed for by staff and relatives who did not have any legal authorisation to do so. This meant the provider was not working within the Mental Capacity Act 2005, and best interest decisions were not being made where people did not have capacity to consent to their own care.

People told us they enjoyed the meals and had access to a good range of snacks and drinks throughout the day.

Care staff treated people with dignity and respect. We observed staff interacting with people kindly and considerately, kneeling by their sides to address them at their own level and being patient when assisting people.

We found there had been some improvement to care plans, however, there was still further work to be done to ensure personal information was included and care plans were written in a person centred way with the person's involvement.

The processes which were in place to monitor the quality and safety of the service were not effective and were not bringing about change. There was evidence that concerns were being identified during audits which were carried out, however there was no action taken to ensure concerns identified were resolved.

Monthly audits were completed and supplied to senior management and the registered provider; however, there was no oversight resulting from this information, as no feedback was given to the manager and no action plans were created.

We found the breach of regulation 16 receiving and acting on complaints had been resolved as the complaints process had sufficiently improved. We found continued breaches of regulation 12 safe care and treatment and regulation 17 good governance. We found additional breaches of regulation 13 safeguarding service users from abuse and improper treatment and regulation 11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Staff demonstrated they understood their roles and responsibilities in making sure people were protected from harm accidents and incidents were recorded and the information was collated, however there was no action taken to reduce the risks identified when the information was analysed. This meant the risk remained.

Medicines management whilst mostly safe, was still an area of concern as the record keeping was not always correct and staff were still not following processes which were in place

We found there was sufficient staff on duty to meet people's needs, however there were still concerns about the safety of the recruitment process which was in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was improved; however it was not always clear from records whether training was face to face or self-directed.

Staff supervision was more consistent and staff reported they found the sessions useful.

Consent to care was not being sought in line with the Mental Capacity Act 2005 (MCA). There was a lack of clarity around people who required a Deprivation of Liberty Safeguard (DoLS), as staff were not clear on who had a current authorisation and the records were difficult to follow.

People spoke positively about the food and we saw people had good access to drinks and snacks throughout the day. People had timely access to healthcare professionals when there was needed.

Is the service caring?

Requires Improvement

The service was not always caring

Staff were kind, considerate and patient in their interactions with people who lived at the home.

We found end of life care plans were not completed, which meant staff would not be aware of the person or their family's wishes for the end of their life.

We found spiritual and cultural needs were not being identified and met by the home.

Is the service responsive?

Requires Improvement

The service was not always responsive

We found there had been some improvements to the care plans which were in place; however there was still further improvement needed to make care plans person centred and remove contradictory information which was still present.

We saw that whilst there was evidence of care plans being reviewed these reviews did not always show that recent information had been taken into account, which meant care plans were not updated accordingly.

We found complaints which had been received since our last inspection had been appropriately recorded, investigated and responded to.

Is the service well-led?

Inadequate

The service was not well-led.

There was auditing taking place, however we found audits were not consistent and not always accurate. Despite some evidence of analysis being carried out there was no evidence the results were being acted upon.

There was no evidence that senior management or the registered provider had oversight of the safety or quality of the service.

Staff reported that the new manager was supportive and accessible.

Epworth House Care Centre

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 took place on 26 July and 4 August 2016 and was unannounced on both days. On both days the inspection was carried out by two adult social care inspectors, with the same lead inspector on both days, with a different supporting inspector each day. On day one there was also 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. The expert-by-experience was experienced in older people's care and the care of people who live with dementia.

Before the inspection we reviewed information we held about the service. This included statutory notifications we had been sent by the service and other correspondence we had received. We used this information to assist with our planning of the inspection and to inform our judgements. We also requested information from local authority commissioners and other agencies who work with the home.

During the inspection we employed a number of different methods to help us understand the views and experiences of people who lived at the home. We spoke with 21 people who lived at the home and 12 relatives; we observed staff interacting with people during their daily routines including meal times. We spoke with two visiting health care professionals, the area manager, the manager, the deputy manager, the administrator and six care staff, one cook and a member of domestic staff.

We looked at a variety of records, including the care files of six people who used the service across the two units, three staff recruitment files, training records, supervision and appraisal records, medication records and all records relating to the monitoring of the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

We looked at the progress the registered provider had made since our last inspection in January 2016, when we found there were breaches of regulation in relation to the safe care and treatment of people who lived at the home and good governance.

We looked at the systems which were in place to protect people from harm and abuse. People who lived at the home told us they felt safe, and their relatives agreed this was the case.

Training records showed staff had received training in safeguarding vulnerable adults, and staff we spoke with were able to demonstrate their knowledge and understanding of the types of abuse and their role in protecting people who lived at the home.

We reviewed the notifications which we had received; we had been notified of a serious incident which had taken place prior to our visit. On the first day of our inspection the manager was not available. We spoke with the area manager and asked them what investigation had been carried out in relation to this incident. The area manager was not able to tell us, and told us the manager was dealing with the matter. We returned to speak with the manager on day two and found there was very little evidence of any investigation having taken place. The manager told us this was because they had been away from the service.

The manager was not able to provide an explanation of how the incident had occurred despite the incident having taken place six weeks earlier. This meant that the person was still at risk as there was no understanding gained of how they had been able to sustain their injuries and no measures had been put in place to ensure this could not happen again in the future.

This is a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the registered provider had not undertaken a thorough investigation of the incident and could not evidence they had put in place any measures to ensure the safety of the person involved.

We reviewed the systems which were in place to ensure people's money was being safely managed by the service. We looked at the records for three people. We saw that money was held and used to pay for services including hairdressing, chiropody and raffles which were held in the home. We found that whilst there were good systems in place to record monies received and monies spent, there was a minor error. This was discussed and rectified to ensure the balance was corrected.

We looked at how the service assessed and managed risks to people.

It had been identified at the last inspection that personal emergency evacuation plans (PEEPs) were not up to date and did not reflect people's current needs for support in an emergency situation. We found PEEPs had been updated and were in place in all the care files we looked at.

We looked at the building and safety check records. We found there were regular checks in place for the fire systems and fire drills were carried out, the member of staff who was responsible for these told us there were 'no concerns'.

We looked at risk assessments which were in place to address specific identified risks to people who used the service; these included nutritional risk, skin integrity assessments, the use of bed rails and equipment to move people. We found that whilst some of these assessments were well completed and showed evidence that the risk had been appropriately assessed and measures had been put in place to minimise the risk, this was not always the case. For example, we found that in two cases the weight information which had been used to calculate nutritional risk did not match the other records which were present in the care file. This meant the result was inaccurate and did not reflect the actual risk. We saw another example where a dependency level assessment had been carried out, the maximum score allowed for the judgement (behaviour) was ten however the assessor had recorded this as 16 and had added up the score incorrectly as a result.

This was a continued breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as records were not accurate.

We looked at the processes which were in place to minimise the risk of infections being present or spread within the home. We found there were cleaning schedules in place and records showed that regular cleaning was being carried out in the home. As a result of the outbreak which occurred at our last inspection which had not been recognised and appropriately dealt with there had been a new process of recording and monitoring infections within the home. We spoke with a member of the domestic staff who said "it's a good job, I like it here. I look at it as if I was cleaning my own home especially the bathrooms and toilets". We also spoke with the laundry assistant who told us "it is very satisfying to see the residents in clean clothes, I love washing and ironing, the only problem is a machine is broken which makes it difficult".

We looked at the processes which were in place for the management of medicines in the home. We looked at the management of controlled drugs in the home. We reviewed the records kept for four people who required controlled drugs; we found the records which were kept of controlled drugs matched the stocks of drugs which were being stored.

We found medication was supplied in monitored dosage systems, which were filled by the pharmacist. We checked the records of five people and found they were correct. There were also people who had as and when needed (PRN) medicines. There were protocols in place to advise staff when people may need these medicines. We saw there was an issue with the recording of PRN medicines. There were gaps in the records and when people had not been given their medicines there was no record of why this was the case.

We looked at the checks which were in place for medicine management. We found that whilst there were regular audits of medicines, these were not reliable as some entries were crossed out and overwritten throughout the records. We discussed this with the manager who told us they were responsible for this, and told us this was due to them making errors when counting. We looked at audits which had been undertaken. We found there were records which showed significant errors, for example there was a discrepancy of 26 tablets in one case and in another case there was a discrepancy of 39 sachets.

The monthly audits consistently showed the same issues had been identified, which included the missing signatures on MARs and staff not recording the date on which medicines in their original packaging had been opened. There was no evidence of improvement of these issues.

This was a continued breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as records were not adequately completed and there was no evidence that auditing and monitoring processes were effective as there was no evidence of improvement in some areas.

We looked at the temperature records for the treatment room where medicines were kept. On day one of the inspection when we visited the ground floor treatment room we found the room to be unpleasantly hot. The temperature records showed the temperature was and had been above the recommended level for storing medicines. This meant that medicines were at risk of not being effective.

This is a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as medicines were not being stored correctly and in line with manufacturer's instructions.

We looked at the recruitment records for four members of staff to review whether the concerns which had been identified at the last inspection had been rectified. We found in one case an employer had not been approached to supply a references to support the staff member's employment from a a previous employer they had listed in their application form. There was no record to show why there had been no employment references gained. We looked at the disclosure and barring service checks (DBS) which were in place. We found one file where this was dated 2002 and another where the staff member's status had not been checked since 2007. There was no process in place to ensure regular checks were made on current staff to ensure they were still of good character. This was discussed with the manager who was unaware of the situation and was not aware of the organisational policy in relation to DBS checks for long standing staff members.

We noted from the action plan which had been submitted since the last inspection, that 'all staff files have been updated and audited'. We found that this audit had not identified all shortfalls which were present on reviewing the files.

This was a continued breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as all necessary improvements had not been made to ensure the recruitment process was safe and effective.

We observed there to be sufficient staff on duty, people were attended to promptly and call bells were answered without undue delay. The dependency tool calculations and staff rotas confirmed this. We saw there was a person who required one to one support; this was being facilitated by the use of agency staff. A relative we spoke with commented "it's ok most of the time but they could do with another pair of hands at mealtimes". Care staff also felt that the staffing levels were adequate and reported they felt they were able to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

We looked at the progress the registered provider had made since our last inspection in January 2016, when we found there were breaches of regulation in relation to the safe care and treatment of people who lived at the home and good governance.

We reviewed the training which staff had undertaken. At the previous inspection some of the staff was not up to date with their training. The manager told us and the records confirmed there had been a significant improvement in the amount of training which staff had done. The training matrix showed a high level of compliance with mandatory training and that staff had access to other training to help them in their daily roles. It was identified at the previous inspection that training in managing behaviour that challenges was needed. This had been completed. The manager told us staff had undertaken training in understanding the Mental Capacity Act and Deprivation of Liberty Safeguards. This was described by the manager as being from the local authority training department. However when we spoke with staff they told us they had completed a booklet on the subject and had not completed the face to face training. The training matrix showed all staff as completing the training and there was no way of knowing which staff had completed which element of the training. This was discussed with the manager who assured us they would amend the training matrix to show this.

Staff told us they received regular supervision, although some of these sessions were group sessions which included a number of staff. Staff did however confirm they had all received individual supervision sessions and that they had found these useful and supportive.

Staff were receiving an annual appraisal with the manager, which allowed them to discuss their performance and development needs and aspirations.

We spoke with staff and found there were varying levels of understanding of the MCA and DoLS. The manager told us they were not clear in their own understanding of the MCA and that they were reading up on the legislation.

We reviewed the records for DoLS and found the file which was in situ was unclear. There was no clear matrix which showed who had been assessed as not having capacity, when a DoLS application had been made, or when the authorisation had been granted. The file contained all DoLS documentation in no particular order, which made it difficult to gain an accurate picture of who had a current authorisation and who was awaiting a decision. There was also no process to monitor when authorisations were coming to the end and a renewal application needed to be made in a timely manner. We asked the manager how many people needed a DoLS, they told us they did not have records that showed this but estimated 25 of the 38 people who lived at the home. When we looked at the records we could only find records relating to 18 people, some of who were no longer living at the home.

We looked at how the registered provider was seeking and gaining consent to care from people who lived at the home. We found there was some evidence that people had been asked to sign a consent form, however

these were people who had been assessed as having capacity to make their own decisions. I asked the manager what would happen in cases where a person had been assessed as not having capacity to give their consent. The manager told us in these cases there may be a conversation with the person's relatives and either the relative or the member of staff would then sign the consent form. We asked the manager whether checks were made to ensure relatives had the legal power to make these decisions in the form of them holding power of attorney (POA) and if so for what decisions. The manager told us they did not recall seeing any POA documents in any of the care files they had reviewed. The manager had told us about an instance where a relative did not want a person to be sent to the hospital. We asked if the relative had POA for health decisions, they said they were now aware of this. On looking at the care file it was recorded the relative had POA for financial decisions only. Despite this issue being highlighted over recent weeks there had been no action taken to clarify the position or to gain a copy of the POA documentation.

This demonstrated a breach of regulation 11 need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider was not seeking and gaining consent from people who used the service in line with the Mental Capacity Act 2005.

The lunchtime meal we observed was served between 12.30 and13.00. There was a choice of main course and pudding. If someone did not want either choice they could request something else. We observed a number of people saying they did not want the pudding choices and they were offered ice cream instead. People who needed most support were seated in the dining room first. A member of staff put some music on which brightened everyone up and many sang along.

We observed staff supporting some people to eat their meals. Staff took their time and did not rush people. A relative told us "[Relative] cannot eat or swallow very well so they puree [relative's] food and [relative] manages that better".

People we spoke with told us the food was good, with comments including "better than it used to be", "the food is lovely" "I really like chicken, when I told them, they got more chicken for me", " I don't like chicken, I like beef and tomatoes so they do that for me". And one person told us, "I enjoyed that." People were offered a choice of juice or lemonade with the meal and then a cup of tea or coffee at the end of the meal. We saw staff offering to top up drinks and offer second helpings to people during the meal.

We saw there were jugs of juice in all the lounges, and people were encouraged to drink regularly. One person told us "I have my can of shandy instead of juice."

The evening meal was sandwiches, soup and a hot choice such as beans on toast, eggs on toast and cakes.

We saw that people had regular access to healthcare services. These visits were recorded in people's care files. We saw there were visits from chiropodists, opticians, district nurses and GPs. Relatives we spoke with said they felt people's health needs were being met. One relative said "I was told there was a red patch on [relative's] skin so they called the district nurse (DN) for advice. The DN visited and [relative] is now on a pressure mattress". We spoke with a member of staff from the Barnsley memory team. They told us "they ring us for advice on managing difficult behaviour in residents with dementia and we will come and visit to provide support as well". Another person told us "I'm diabetic and if I need the doctor they will get one for me."

Requires Improvement

Is the service caring?

Our findings

One person who used the service told us "I came here because it was recommended by my [relative's] friend, I'm quite happy here, they look after me well". Relatives told us, "the staff are brilliant" and "the care is exemplary. I come regularly, at all times of day and even late evening and it is always the same. I've never seen anything untoward". Another person told us "the carers are good and that's the main thing. I get good care and service. If I need someone they are there, they even come in and check on me during the night to make sure I'm alright."

People we spoke with said they felt their needs were met by the staff. The relative of a person who lived at the home told us "[Relative] was really poorly in January. They let us stay as long as we wanted to. [Relative] is doing really well now. They have been really good with [relative]".

We saw that care staff were kind, caring and patient and it was apparent care staff knew people well, and knew what people's likes and preferences were. The interactions between staff and people who lived at the home was positive, friendly and cheerful. We observed staff lowered themselves to the level of the person they were addressing, made and maintained eye contact and smiled at the person. Staff spoke of people fondly and spoke with passion about their roles.

We looked at whether the home was recognising and meeting people's needs in relation to their religious beliefs or their cultural needs. We found there was a person for whom English was not their first language; we were told they had recently needed the services of an interpreter in order for an assessment to be carried out by another agency. We asked the manager how the person usually communicated. They told us 'they don't say much'; we asked if this was due to the language barrier. The manager was unsure. There were no services in place to allow the person to communicate in their native language and no consideration had been given to any other needs they may have, for example, food choices. We asked the manager whether there was any provision for people to have access to religious services. They told us there was no provision to meet people's spiritual needs; however they said they would look into this.

People we spoke with told us they were unable to recall any resident meetings which had taken place recently. Resident meetings are an important opportunity for people to express their opinions in relation to the running of the home in which they live.

A relative told us "[Relative's] privacy and dignity are taken into account at all times. The staff aren't recognised for all they do. They do their very best". Another relative told us "They are marvellous to [relative]. [Relative] is very happy here". We did not see or hear anything during the inspection which would compromise people's privacy.

Relatives of people who lived at the home told us "there are no restrictions on visiting, we can come any time". We observed this was the case and spoke with family who were visiting together. Another relative told us, "[Relative] is happy. [Relative] has a big family and they all visit from all over, for example [relative's sister comes every 3rd Wednesday]. We are always welcome".

We looked at the provision which was in place for people who were at the end of their lives. We found there was a section in the care plan where people's wishes could be recorded. We reviewed the care plan for a person who was at the end of their life. We found the care plan was not complete and the sections about the support which was needed were not filled out. However when we asked the manager about the care plan they told us they had reviewed it and were satisfied that it was detailed and complete. This meant staff did not have access to the information they needed to care for the person at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

We looked at the progress the registered provider had made since our last inspection in January 2016, when we found there were breaches of regulation in relation to the good governance and receiving and acting on complaints.

We reviewed the process which was in place for recording and dealing with complaints which were received. This had been a concern at our last inspection. We found the process had improved and saw that complaints which had been received were appropriately recorded, investigated and responded to. A person who lived at the home told us "if I had a complaint I would speak to the manager or senior on duty".

Relatives told us "If I had a concern I'd speak to (manager)" another relative said "I would speak to the manager or senior carer on duty" and "[Relative is] content here and we are as well".

We reviewed the care plans which were in place for six people who used the service. We found that whilst there had been some work carried out on the care plans since our last visit, there was still further work required to ensure that all care plans were detailed and person-centred. We found instances where there was conflicting information contained in different sections of care files. For instance in one case there was a copy of a Do Not Attempt Cardio Pulmonary Resuscitation order (DNACPR) in place, yet one of the recent assessments asked if there was a DNACPR and this had been answered 'No'. We discussed the care plans with the manager who agreed the care plans were not person centred enough, and that there was conflicting information which could lead to errors in the support being given. The manager told us they had an alternate format which could be used to improve care plans, however there was no timescale for this to be implemented.

We asked the manager how they ensured people were involved in the creation and review of their care plans. The manager said people were asked about their care plans and if appropriate their relatives were also consulted; however there was no evidence that this was the case in the care files we reviewed. We saw there was information relating to people's life stories which was in some cases very detailed, however, this was variable and not the case in all the care files we reviewed. A relative told us "They [care plans] are kept in the office but I can pick it up any time to see what is happening with mum. There has been an improvement in them since the new manager came".

We saw there were reviews carried out of the care plans which were in place, however the manager told us and records confirmed, there was little evidence that these reviews took into account recent events or changes to people's health or support needs. Most of the entries seen were generic and stated 'no change to needs' and in one case we saw there had been no reviews carried out despite the documentation stating there should be monthly reviews carried out.

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

We spoke with people and relatives about activities which took place in the home. One relative told us "[Relative] used to love gardening and they have let me put a corner of the courtyard together where we can go and look after some plants in pots." We observed there were activities taking place in the home on the two days we visited. This included bingo and staff having a sing-a-long with some people on the first floor unit. Staff encouraged one person to sing to a member of the inspection team, which they did and clearly enjoyed.

One person told us "I don't like the light so I have to stay in my room with my music. They bring me drinks to my room. I would like to go into the lounge but it is too bright. The staff sometimes bring another resident I know to sit in my room with me". This person was at risk of social isolation as they were unable to sit in communal areas as they did not meet their needs.

We observed throughout the inspection staff offering choice to people who lived at the home; this was part of the daily routine. People we spoke with confirmed they were always offered a choice and gave examples of meals and drinks, what they wanted to wear and whether they wanted to join in with activities which were taking place.

Inadequate

Is the service well-led?

Our findings

We looked at the progress the registered provider had made since our last inspection in January 2016, when we found there were breaches of regulation in relation to the good governance.

The home did not have a registered manager in post; however there was a manager who had been in post since the end of January 2016, who told us it was their intention to register with the Care Quality Commission. There was an area manager who was present on the first day of our inspection. They told us they had become involved in the home as a consultant initially.

Relatives we spoke with said things had improved since the new manager had been in post. One said, "[Manager] is approachable. When you see [manager] around they always says hello and speak to me". One person's relative said they had written a letter to the manager when they started about where they thought things could be better and said, "[Manager] responded positively to it".

The manager told us there was a culture of change in the home since they had started at the end of January 2016. Staff we spoke with told us morale had improved since the new manager had been in post, and staff felt the manager was approachable and supportive. Staff reported staff meetings were taking place and they were able to discuss anything which was bothering them.

The manager told us they operated an open door policy. This was confirmed by staff, people who lived at the home and their relatives. The manager told us they were open in their communication with staff and people who used the service and their relatives, we saw there had been a meeting held to introduce the new manager when they commenced their role. However people who lived at the home and their relatives were not able to recall any meetings that had been held for them.

We looked at the processes which were in place to monitor the quality and safety of the home and the support given to people who lived there.

We found there were auditing processes in place. The weekly checks were gathered together in a monthly based auditing process. There was a programme at the front of the file showing which audits should be completed every month and where audits were not monthly in which month they were to be completed. These less frequent audits included end of life care, mental health and health and safety.

We saw there should have been a monthly audit of medication records and stocks. We found there had been no monthly audits completed for April or May 2016. We asked the manager about this and they seemed surprised, however, confirmed after checking the file that these key audits had not been completed. We saw from the audits which had been completed the same issues were identified each month. We asked the manager what action had been taken to resolve these issues. They told us they had taken some disciplinary action, however, this was not recorded in the audit file, and we could find no evidence of action plans which had been created to ensure the shortfalls were addressed.

We looked at the monthly action plan for weight loss. We found there were errors and inconsistencies in the calculations which were recorded. For example we saw one entry where it was recorded the person had lost 13% of their body weight. On checking the records it was found the person had actually gained weight. There was another entry where it was recorded the person had lost 9% of their body weight. On checking the records it was found the person had lost 15% of their body weight. We also found concerns with the actions which were logged. In one case the person had lost 11% of their body weight, yet the action recorded was to make a referral to a dietician if the loss reached 5%.

We reviewed the auditing and analysis which had taken place in relation the accidents and incidents in the home. There was detailed information and this had been analysed to show where in the home accidents had occurred and what times of day. No actions were identified from the analysis We found there were significant concerns with the results of the analysis. For example in May 2016 there had been 23 accidents in the home, of these 18 were unwitnessed, and nine of the unwitnessed falls had happened between 7:30 and 13:30 when there should be staff around supporting people. In April 16 the audit recorded there had been 13 accidents of which 12 were unwitnessed. Of these13, eight accidents resulted in emergency services being called and four resulted in a hospital admission.

There was no evidence of any action plans being created or action having been taken to address the risks which were evident, for example, staffing levels reviewed due to the high level of unwitnessed falls.

We looked at other audits including care file audits which again showed the same issues being identified each month and no evidence of action being taken to improve these areas.

We asked the manager what oversight there was from the area manager and the registered provider. The manager told us they send the audits to both the area manager and the registered provider each month. The manager when asked confirmed they received little to no feedback on the audits. When speaking to the area manager on the first day of our inspection we highlighted the shortcomings with the audits and the area manager was unaware of the issues and told us they were 'disappointed' with the quality and accuracy. This showed the auditing processes were not effective and did not identify failings within the service. This also evidenced there was no oversight of the monitoring of the quality and safety of the service from the senior manager or the registered provider.

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

We asked the newly appointed manager what support they had from senior managers, they told us when the last area manager had been in post they visited the home at least once per week and often twice per week to offer support and guidance. They told us since the change of area manager this was now usually one visit per fortnight, but did say they could ask for extra visits if necessary.

We asked the manager about the home's vision and values, the manager was not clear about what we meant by this and was unable to tell us whether there were any and if so where these would be found.

We identified during the inspection that the lift had been out of operation for a number of days in the preceding week. We had not been notified of this. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The failure of the lift had meant that some people needed to temporarily move bedrooms as they were unable to use the stairs. We asked the area manager to ensure that a notification be sent without further

delay, however, when we returned to the home for the second day of inspection we found this had not been completed. We asked the manager who should notify us in their absence, they told us there was no process in place to ensure this would happen. This meant the registered provider had not made provision to ensure their registration requirements were met.

We looked at the progress the registered provider had made since our last inspection in January 2016, when we found there were breaches of regulation in relation to the good governance.

The home did not have a registered manager in post; however there was a manager who had been in post since the end of January 2016, who told us it was their intention to register with the Care Quality Commission. There was an area manager who was present on the first day of our inspection. They told us they had become involved in the home as a consultant initially.

Relatives we spoke with said things had improved since the new manager had been in post. One said, "[Manager] is approachable. When you see [manager] around they always says hello and speak to me". One person's relative said they had written a letter to the manager when they started about where they thought things could be better and said, "[Manager] responded positively to it".

The manager told us there was a culture of change in the home since they had started at the end of January 2016. Staff we spoke with told us morale had improved since the new manager had been in post, and staff felt the manager was approachable and supportive. Staff reported staff meetings were taking place and they were able to discuss anything which was bothering them.

The manager told us they operated an open door policy. This was confirmed by staff, people who lived at the home and their relatives. The manager told us they were open in their communication with staff and people who used the service and their relatives, we saw there had been a meeting held to introduce the new manager when they commenced their role. However people who lived at the home and their relatives were not able to recall any meetings that had been held for them.

We looked at the processes which were in place to monitor the quality and safety of the home and the support given to people who lived there.

We found there were auditing processes in place. The weekly checks were gathered together in a monthly based auditing process. There was a programme at the front of the file showing which audits should be completed every month and where audits were not monthly in which month they were to be completed. These less frequent audits included end of life care, mental health and health and safety.

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