Baybury Limited

The Orchards Care Home

Inspection report

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Date of inspection visit: 24 September 2015
Date of publication: 17/11/2015

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**

Overall summary

The Orchards Care Home is a large three storey converted house with a garden situated about three miles from Bradford city centre. The home provides care without nursing to a maximum of 22 people.

This was an unannounced inspection which took place on 24 September 2015. On the date of the inspection there were 17 people living in the home.

A registered manager was in place. 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. However the registered manager was not in day to day charge of the service. The home lacked adequate management and leadership with a lack of supernumerary time allocated to the running of the service. We found this had a significant impact on the quality of the service.

In October 2014 we found a number of breaches of regulation, when we returned in April 2015 we found improvements had been made. However since the last inspection in April 2015 care quality had slipped again.

Summary of findings

This should have been prevented through strong leadership and management of the service. There were inadequate checking and auditing systems in place to ensure robust documentation was maintained, medication safely administered and to ensure staffing levels were safe. On the day of the inspection the registered manager confirmed they had appointed a new home manager who would work supernumerary which would allow them to address the issues identified during the inspection.

People told us they felt safe and secure in the home and did not raise any concerns over their safety. Staff had a basic understanding of safeguarding but were unable to tell us how to raise an alert with the safeguarding authority.

Incidents and accidents had not always been investigated to keep people safe. This increased the chance that incidents would reoccur.

Medicines were not managed safely. People did not receive their medicines as prescribed and staff did not demonstrate an adequate knowledge of the medicines they were administrating. Record keeping of medicine stock levels were poor, meaning there was a lack of accountability for medicines stored in the home.

Safe recruitment processes were not in place as key information relating to staff character and qualifications was missing.

We found people experienced delays in care and support as staffing levels were not adequate both during the day and at night. The registered manager told us they recognised staffing levels were not sufficient and would ensure increases were made promptly once new staff started.

People reported the food in the home was good and said there was sufficient choice. However we found nutritional risks were not always well managed. A lack of action had been taken to mitigate the risks of malnutrition to one person who used the service.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The service had made a number of DoLS applications where it suspected it was depriving people of their liberty and was awaiting feedback from the supervisory body.

We observed care and found people were treated with dignity and respect by staff. People and their relatives told us that staff were always kind and treated them well.

A system was in place to ensure people knew how to complain and ensure any complaints were responded to. However documentation demonstrating follow up and learning from complaints was not always present.

There was a lack of activities provided in the home. Despite an activities schedule being in place we saw it was not followed and we observed staff did not have time to engage in activities with people who used the service.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

The overall rating for this service is ‘Inadequate’ and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider’s registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe."

Summary of findings

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.

Medicines were not administered safely. Some people did not receive their medicines as prescribed and staff on duty showed a lack of knowledge about the medicines they were administering.

There were insufficient care staff deployed during both day and night shifts to ensure people's needs were consistently met.

Risks to people's health, safety and welfare were not properly assessed and mitigated.

Is the service effective?

Requires improvement

The service was not always effective.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People spoke positively about the food and it looked plentiful and appetising. However nutritional risks were not always safely managed. We found a lack of action to address nutritional risks to one person who used the service.

Staff demonstrated a lack of knowledge about some of the subjects we asked them about, including medicines and safeguarding. Mandatory training was overdue for existing staff and some new staff were missing induction and training records.

Is the service caring?

Requires improvement

The service was not always caring.

People and their relatives spoke positively about the attitude of staff and said they were kind and caring. During the inspection, we observed some good positive interactions between staff and people.

However we observed there was a lack of attention to detail by staff. Some people did not receive timely care and staff were unable to offer a person centred approach to care and support.

Is the service responsive?

Requires improvement

Care was not always responsive.

People had a range of care plans in place but these often lacked sufficient detail to provide staff with instruction on how to deliver personalised care and support.

We found a lack of activities provided to people with care staff too busy completing care and support tasks to engage in meaningful activity.

Summary of findings

People and their relatives said they were generally happy with the service and had no cause to complain.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of management presence in the home and we found this had a significant impact on the quality of the service. Care quality had slipped since the previous inspection and we found several breaches of regulation. This should have been prevented through strong leadership and management of the service.

Quality assurance systems were not robust in identifying and rectifying issues for example with regards to medication, care records and records relating to the management of the service such as training and recruitment.

The Orchards Care 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 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 24 September 2015 and was unannounced. The inspection team consisted of two inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support in the lounge and communal areas of the home. We spoke with six people who used the service, two relatives, five care workers, the cook, the registered manager and the newly reinstated home manager. We looked at a number of people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to our inspection we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all information we held about the provider.

As part of the inspection we also spoke with two health and social care professionals to ask them about their views on the service. We also spoke with the local authority commissioning and safeguarding teams.

Inadequate

Is the service safe?

Our findings

We reviewed medicine administration records (MAR) and on seven people's MAR, found gaps where staff had not signed the record to show if the medicine had been given or omitted for any reason. When we checked these with a senior care staff member we determined three people had not received some of their medicines as they were still in the medication box. In some instances we were not able to ascertain if people had received their medicines as no stock levels were recorded on the MARs. The staff member told us stock levels used to be recorded when medicines were received into the home but this had now stopped.

We found senior staff lacked knowledge about the medicines they were giving. For example, one person was prescribed a medicine that had to be given 30 to 60 minutes before food. We saw the person was given this medicine after their breakfast and when we raised this with the staff member they said they did not know the medicine had these instructions even though this was clearly recorded on the MAR. We saw another person was prescribed an anticoagulant (a blood thinner) which has certain effects which staff need to be aware of. We asked staff if they knew what this medicine was for and they told us they did not. We looked at the medicines guidance that was kept with the medicine trolley, but neither reference book contained information about this medicine. One reference book (British National Formulary) was dated 2005. The BNF is updated and re-published every year.

We saw where people were prescribed topical creams or gels there was not always a record to show these had been administered. There were no instructions on or with the MAR to show where the cream or gel should be applied. There was no guidance for staff to show when or how often 'as required medicines' should be given. Where the MAR stated one or two tablets could be given there was no record to show the number of tablets that had been administered.

We looked at the medicine policy dated November 2014 which was kept with the medicine trolley. We found the policy contained limited information and did not refer to The National Institute for Health and Care Excellence (NICE) guidelines: Managing medicines in care homes. There was no information about covert medication and the guidance about 'as required' medicines stated, 'if directions state 'to be taken as required' somehow you need to find out whether the person has any pain' but did not provide any further detail about how this was to be done.

We were concerned about the security and safe storage of some medicines. For example, we found insulin and eye drops were stored in the domestic fridge in the kitchen which all staff had access to. We saw the home had a medication fridge but this was not in use. We reported this to the registered manager who took immediate action to ensure these medicines were stored appropriately. We observed the medicine keys were left on top of the medicine trolley in the dining room for an hour which meant anyone could have accessed the medicine trolley. The senior staff member told us this had been a mistake and said they usually kept the keys with them.

Three people were prescribed controlled drugs. We found these were stored and recorded correctly in the controlled drugs register and stock levels balanced. We saw when staff administered medicines to people they took the person a drink and stayed with them to make sure the medicines had been taken. However, we observed the staff member giving the morning medicines was continually interrupted. They were one of only two care staff on duty and as well as giving out medicines they were giving people their breakfast, answering the phone and the door and going to give assistance to the other staff member. This increased the risk of medication errors.

This was a breach of the Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe in the home. Staff we spoke with confirmed they had received safeguarding training however we found they had a limited understanding and although they told us they would report any concerns to the manager, they were not confident about the process of reporting concerns themselves directly to safeguarding or other agencies.

We looked at risk assessments in people's care records and found there was a lack of guidance and detail to support staff to manage risks. For example, one person's records showed they were at times verbally and physically aggressive towards other people and staff. The care plans directed staff to follow the behaviour management plan at all times, yet this plan was blank. Another person's records

showed they had sustained six falls in August 2015, yet the falls risk assessment completed in September 2015 made no reference to these falls and the care plans provided general rather than specific information about how to keep this person safe.

Prior to the inspection we spoke with acting manager at the time about a notification and a subsequent protection plan to help keep a person safe. They told us in an email that the person was to be subject to daily body checks by the home to ensure any signs of abuse were quickly recognised. However when we viewed this person's care records there was no daily recorded checks taking place.

Records showed incidents were not always reported on incidents and accident forms and fully investigated to ensure people were kept safe. For example handover records showed that a person had a choking episode in July 2015 and staff had to intervene, however this had not been reported as an incident and there was no evidence of any action taken to prevent a re-occurrence. Another person's care records showed they had sustained a cut to their wrist and a graze to their right knee. There was no evidence to show this had been fully investigated or reported as an incident/accident. Another person had suffered a number of falls whilst on day care at the home but there was no incident form or investigation completed.

This was a breach of the Regulation 12 (2a& b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found in the days prior to the inspection, the home had taken steps to improve the way incidents and accidents were reported. A significant event form which was used earlier in 2015 had recently been reintroduced. This would help to ensure incidents were correctly reported and investigated in the future.

Prior to the inspection we received concerns from a visiting health professional that staffing levels were unsafe. We arrived at the home at 7.30am and there were two care staff on duty to care for the 17 people living in the home. The registered manager, care workers and rotas confirmed this was typical of recent weeks. An additional staff member arrived late morning who told us they had been asked to come in early as they were due to start at 2pm. Staff told us five of the people required two staff to assist them during the day, which meant when both staff were assisting a person there were no staff available to attend to or supervise other people. In addition, between them the two care staff on duty had to answer the door and phone, administer medication and do the laundry. Our observations showed there were insufficient staff to meet people's needs. We saw a person in the lounge struggling to get out of their chair and two other people were trying to help the person stand up. The person told us they wanted to go to the toilet. No care staff were around; we intervened and found a domestic staff member who went to locate the care staff while we remained with the person. We saw two people in the dining room kept asking for their breakfast and waited twenty minutes before it arrived as staff were busy attending to other people. We saw one person who required assistance to move was sat in their wheelchair at the dining room table for two hours after breakfast as staff were attending to other people. We saw there were no activities provided to people and staff didn't have time to meet people's social needs. Records of daily care also showed that one person who visited to attend day care had fallen a number of times in one day, this indicated that staffing levels were not sufficient to safely supervise this person.

A relative we spoke with told us they felt there were not enough staff. All the staff we spoke with told us they needed more staff. One staff member told us that at weekends there was no cook and said an additional staff member was usually brought in to do the cooking on these days. They told us there had been occasions when there had not been a third staff member which meant the two care staff on duty had to do the cooking as well as care tasks, laundry duties and answering the phone/dealing with any queries. At night there was one staff member working with another on call able to respond to specific incidents or concerns. We concluded this was insufficient to care for the people that needed assistance at night. One staff member confirmed how one person often needed two people for continence whilst in bed but as there were not two staff routinely on duty it was often done by one staff member which was at times challenging.

There were insufficient staff deployed for the management of the service. The registered manager was not in day to day control of the service, staff confirmed this for example one care worker told us "she rarely visits". The home manager only worked part time and most of the time they worked this was on shift as a care worker and not in a supernumerary capacity.

Inadequate

Is the service safe?

The registered manager told us they recognised the need to increase staffing levels from two to three during the day and to two at night, and would be able to do this once new staff started the week following the inspection. However we were particularly concerned that this deficiency in staffing had been allowed to occur in the first place and the home had accepted new referrals which increased the occupancy level to 17 without making appropriate staffing arrangements.

Following the inspection the provider sent us an action plan and a rota for the following week showing us the changes made. Supernumerary time had now been provided for the new home manager. Some increases in staffing levels had been made although the rota showed this was not yet consistently in place. In addition there was also no cover provided for the cleaner whilst they were on annual leave putting more pressure on care staff, and the rota showed the home was still unable to consistently maintain two staff at night.

This was a breach of the Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practice was not in place. We looked at the files of three new staff. We found one was well completed with the necessary checks on their character, verifications of qualifications and record of a full induction to the service. However a second staff member's file was missing any references and there were no checks on their qualifications. A third staff member was completely missing a recruitment file , the registered manager told us that this was because they had worked for the provider back in 2012 and the home manager had not followed the correct procedures on reemploying them. Following us raising the issue during the inspection we saw safeguards had been put in place to prevent a re-occurrence and ensure these staff were subject to supervision until the required checks had been completed.

This was a breach of the Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook a tour of the premises. We found the home to be adequately maintained. Rooms were homely and people we spoke with said they had no concerns with their room or the building General décor was tired in a number of areas such as some damaged and scuffed door frames and some wallpaper peeling from walls. A purpose built disabled entrance was in place which meant there was safe access and egress for people who used wheelchairs. We found fire exits to be clear of debris and blockages. Some of the minor issues we identified at the last inspection such as a damaged window had been addressed. At the last inspection we were concerned that it was cold in the home. During this inspection we found the home to be warmer with the heating operating and the temperatures in the lounges now between 20C to 22C rather than the 18C we found during April 2015 inspection.

We looked at documentation relating to the premises and equipment. Checks on water temperatures had been recorded monthly but ceased from April 2015 onwards, when management arrangements changed at the home. Fire alarm tests were undertaken. We asked to see electrical and gas records however these were not provided to us at the inspection nor promptly afterwards.

We found the home to be clean with no offensive odours. Bedrooms, furniture and bedding was regularly cleaned and we saw the cleaner worked hard throughout the day to ensure all areas were kept clean and fresh.

Requires improvement

Is the service effective?

Our findings

People and relatives we spoke with were positive about the care and support provided by the home and did not raise any concerns over the effectiveness of care.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. Appropriate applications had been made to the supervisory authority for people without capacity who the home deemed were being restricted on their liberty. This had been done for existing people and promptly following new people moving to the home. The action taken by the service demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and DoLS and as such they were operating within the required legal framework.

We found some gaps in staff skill and knowledge. For example staff were unable to describe the MCA or how to raise a safeguarding alert and there were gaps in the medication knowledge of the senior carer we spoke with. Staff were overdue training updates in a number of areas including safeguarding, MCA, infection control, dementia and fire training. The registered manager told us that getting staff to complete training had been an issue. Most staff had received training in manual handling which was conducted by the registered manager, and medication training had been provided to senior staff. Training from external health professionals in pressure area care had been provided. We looked at the induction for three new members of staff. One training record was well completed with training, for example with local induction documents and fire checklists completed. However we looked at one new member of staff who started in 2015. They had not undertaken any training or had an induction to the service and their training record was blank. Another two staff members who started in 2014 had not completed their mandatory training.

This was a breach of the Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food provided by the home. On the day of inspection we arrived at the home at 7.30am and there were nine people in the dining room having breakfast. We saw people were offered cereal, porridge, toast and egg sandwiches. We sat with people in the dining room while they had their lunch. However there were no menus on display and when we asked people what was for lunch they said they didn't know. The food arrived already plated and covered via a service lift from the kitchen below which meant people sitting together received their meals at different times. The food looked appetising and people told us they enjoyed it. One person said, "This is lovely and it tastes as good as it looks." We saw people were offered gravy separately and had access to condiments and were offered a hot drink. We spoke with the cook who had a good knowledge of people's likes and dislikes which were recorded. Menus were devised on a four week cycle and showed a choice at each meal which included a vegetarian option.

We found people's weight and nutritional needs were not consistently monitored effectively. For example, we saw one person's weight on admission to the home on 30 August 2015 was 37.7kgs and the records showed they had lost 16kgs in the month prior to their admission. Although the care plan stated the person was to be weighed weekly, no weights had been recorded since their admission. A request had been made to the GP requesting a referral to a dietician but there was no evidence to show this had been followed up. We looked at the food and fluid charts for this person and found these were not being monitored by staff and there was no evidence to show any action had been taken when food and fluid intake was poor. For example, on one day the person had refused all food and had a total intake of 250mls of fluid, the next day the person had no breakfast or lunch, a small amount of food for tea and their fluid intake consisted of three cups of tea. Due to this risk, following the inspection we made a safeguarding referral.

This was a breach of the Regulation 12 (2a&b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed people had access to healthcare services such as GPs, district nurses, optician and social workers. Health related care plans were in place for example to help manage diabetes to help staff meet their needs in this area. The social care professional we spoke with told us the two

Requires improvement

Is the service effective?

people they were visiting had settled in well to the home and one in particular had improved considerably since they had been admitted to the home. They described the home as having done 'brilliantly' in caring for this person.

Requires improvement

Is the service caring?

Our findings

We spoke with two relatives who were complimentary about the care their family members received. They told us staff were very good and kind. People we spoke with also said staff were kind and compassionate. For example one person told us "Very kind and helpful staff , very friendly." We spoke with a visiting social care professional who told us they found staff were very pleasant and caring towards people. They said they had spoken with an advocate who had been in to see one person and they had also praised the staff and described them as friendly and caring.

When staff interacted with people, we observed they were kind and caring, friendly, talking to people and helping to calm any anxieties and trying to respond to their requests. For example two people commented on the temperature in the dining room saying they felt cold. Staff brought one person a blanket and then turned up the radiator in the room demonstrating they were listening to people's comments. We saw staff got another person a jigsaw to help them occupy themselves.

We saw staff respected people's privacy for example knocking on their doors before assisting with personal care.

However, we found as staff were constantly busy rushing from one person to another there were times when things were missed. For example, staff brought one person a drink and did not notice the person had saliva hanging from their chin until we pointed this out when they returned to offer the person a biscuit. We observed one person coughed up some discharge onto their shoes. Despite staff entering the lounge several times during the following 50 minute period, they did not notice this and we had to point this out to staff.

We concluded the service was not consistently caring as there were not sufficient staff to ensure a person centred approach to care and support. Staff were unable to spend social time with people listening to them or providing companionship. One person told us how they liked walking but staff did not have the time to help or support them in this area and as a consequence their independence suffered.

Staff we spoke with demonstrated a good awareness of how to ensure people received dignified care and were treated with respect. They demonstrated a good understanding of the people they were caring for. We found information was present within people's care plans to help staff understand about their biography and history to help achieve personalised care. Care plans considered that people's choices and preferences with regards to their care and support were key.

Some mechanisms were in place to listen to people. However there was a lack of evidence people and/or their relatives had been involved in regular reviews of their care and their comments recorded .

People could visit the service when they wanted to and relatives and people reported no restrictions.

Requires improvement

Is the service responsive?

Our findings

People had care plans in place designed to assist staff to provide appropriate care. These included assessments at admission and then a range of care plans based on their needs for example covering areas such as personal care, mobility and continence. Information on people's life history was present within files to help staff to understand the people they were caring for. However we found care records were not always person-centred and lacked the required level of detail for personalised care. For example, the care plan to support one person's continence needs showed the action to be taken was to 'toilet as required, change pads as required, record on relevant documentation and report changes to district nurses'. Another person's records showed their preference was to eat in their room as they didn't like people watching them, yet their care plan said to encourage the person to eat in the dining room. One person was having a pressure assessment completed monthly, this stopped in April 2015 with no further entries. This showed that a full assessment of their needs had not been continuously carried out.

This was a breach of the Regulation 17 (2c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of people had pressure reliving equipment such as cushions to reduce the risk of pressure sores and problems with skin integrity. We saw these were utilised correctly in line with people's plans of care.

Handover records were in place which provided summary of any changes to people's needs to ensure any key messages were passed onto staff. Daily records were maintained which provided evidence of the care and support people had received, although at times these lacked sufficient information. A detailed programme of night checks had just been implemented to provide assurance that night staff were completing the required tasks. We found this were reasonably well completed providing evidence that people had received checks for example every two to four hours as required.

We found there was a lack of person centred activities provided by the home. The July 2015 home newsletter described how a new programme of activities was in place. An activities board detailed a variety of activities scheduled to take place each morning and afternoon. On the day of the inspection it stated games console, chair aerobics and ball games would take place. However we observed no activities taking place during our inspection. We saw one person in the afternoon sat at the table with dominoes spread out who kept repeatedly asking if someone would play a game with them. No one played although one staff member promised they would later. We saw people in the lounge had nothing to do other than watch television which was on all day. Following the inspection we received an action plan from the manager who confirmed they would review the activities and ensure a person centred activities plan was put in place within two weeks.

A complaints policy was in place. However details of how to complain were not prominently displayed and there were no contact details for management on display. People and relatives we spoke with said they had no cause to complain about the service. We found one complaint had been received within 2015 and we saw evidence the service had met with the complainant to discuss the complaint which was partially about a staff members conduct. However we found there was no formal supervision or record of discussion with the staff member concerned to help reduce the risk of a re-occurrence.

Inadequate

Is the service well-led?

Our findings

We found the provider had reported most required notifications such as allegations of abuse, serious injuries and deaths in the home. However we found one required notification where the passenger lift was out of order for several days had not been reported to us. We reminded the provider of the need to ensure that all required notifications were submitted to us.

In the April 2015 inspection report, whilst we found improvements had been made, we raised concerns about the risk that this would not be sustained. This was because there was a lack of dedicated management support at the home, with the home manager at the time also working for another care provider and the registered manager having other responsibilities outside the service. We were concerned that this would lead to overly stretched management resources, particularly if the occupancy increased. Shortly after the last inspection, the previous home manager had left the service and the previous deputy manager had taken over running the home. However there was insufficient supernumerary time allocated for them to conduct their management duties as they only worked part time and when they did work, the majority of the time this was as one of the care workers on shift. This meant a manager was often not present to oversee the service and conduct management duties. Since the last inspection in April 2015, the home's occupancy had increased from 10 to 17 residents, however management support to manage this increased workload had decreased.

Staff we spoke with confirmed there was not a manager present most of the time and said there was no agreed route to contact them with any concerns. One staff member said they only had the email address of the registered manager and no contact details for the home manager, whilst another said they would not go to the home manager with any issues.

We found the lack of management support and insufficient staffing levels had a significant impact on the quality of the service. We identified a number of breaches of regulation namely in respect of medicine management, assessing and mitigating risks to people's health and safety, staffing levels, recruitment, training and care records. We were particularly concerned that the quality of the service had once again substantially declined. In October 2014, we found a number of breaches of regulation and were assured that the new home manager at the time would improve the quality of the service. Although they had done this, after their departure in April 2015, the systems and processes they had put in place had not been effectively utilised and the service had experienced a decline in quality. Specific examples included no longer maintaining cleaning schedules, water temperature checks not completed, poor care plan updates, incidents and accidents not being consistently reported and stock levels of medicines not routinely recorded. This showed overall poor management and leadership in consistently maintaining an acceptable level of service.

On the day of the inspection, the registered manager told us they recognised that the home needed a dedicated manager and confirmed to us they were going to reinstate the former home manager on a permanent basis as a supernumerary member of staff. During the inspection, we saw they arrived and began undertaking management duties. Whilst this was encouraging, we were concerned this had only been done reactively following concerns identified by the Commission and external health professionals.

The breaches in regulation we identified during this inspection should have been identified and rectified through a robust system of quality assurance. We saw some audits had been undertaken by the service. For example a recent medication audit and care plan audit had been undertaken. However these were not sufficiently robust in identifying and rectifying risks. For example we found the care plan audit had only looked at one care plan and the medication audit had not identified some of the issues we found during the inspection. We found staffing levels were insufficient, and the registered manager told us that at the time of the inspection, they did not have sufficient staff to ensure the required number of staff were on shift. There had been a number of new people admitted to the home. Good leadership would have ensured that these people were not admitted without ensuring the home had the required staff on duty. People's dependencies were calculated however this was not used to inform staffing levels and there were no observations audits on whether there were sufficient staff in the building. A human resources audit had been devised, but it had not been completed. Had it been utilised correctly it would

Inadequate

Is the service well-led?

have identified the failings with regards to recruitment procedures and induction training. No provider audit to oversee the general quality had been completed since the last inspection.

We found policies and procedural documents were out of date. For example the policy for the management and prevention of pressure sores was dated November 2010. There was evidence on the back that some staff had signed to demonstrate they had read the polices but no new staff had signed since October 2014 . This meant there was a risk they were not aware of the procedures they were required to follow. We raised this with the registered manager who recognised the need to ensure all policies and procedures were reviewed. We also found evidence some policies were not followed. For example the fire safety policy stated that in house fire safety sessions would be held every three months, but we found this was not the case. There was no robust system to monitor whether the provider was working to its own policies and procedures.

No competency assessments were completed on staff to inform the staff training programme. We found gaps in staff knowledge which could have been identified and addressed by checks on staff competency.

We saw some quality issues were addressed through handover records, However there was no proper check to determine whether actions had been carried through and improvements made. Some of the comments in the handover records were not appropriate for example it was recorded in relation to medicine management “Please can night staff check MAR’s and sign for dates that have been missed accordingly”, which simply sought to correct the records rather than investigating whether people had missed medication and whether there was an impact on their health.

Incident and accident records were poorly completed and we saw actions were not always in place following incidents. A number of incidents and accidents had not been reported on the system. There was no analysis of incidents to look for any trends for example the time of day or number of falls to particular residents.

Records were not promptly located for us during the inspection. We found records relating to the management of the service such as training and recruitment were disorganised and/or missing.

This was a breach of the Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a recent staff meeting had taken place and there was evidence that recent concerns raised by external health professionals had been discussed and begun to be addressed for example through more robust monitoring of night time care and support.

Staff had not received a documented supervision, the registered manager said some of these had taken place informally but had not been documented. However there was no evidence this was the case and without documentation, required actions, goals and objectives, were not recorded.

Care records were kept confidentially within the necessary cupboard. Staff recognised the importance of ensuring that records were kept secure for example to ensure they were kept confidential from visitors.

Following the inspection, the registered manager and home manager provided us with an action plan stating how they would address the significant concerns we identified during the inspection. They told us the newly instated home manager was going to apply to be registered manager so that the person legally responsible for the service was in day to day control of the service. Although we were encouraged that a plan was now in place to begin addressing issues, we were concerned that the quality of the service had not been adequately monitored by the provider to prevent these failings from occurring in the first place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Effective recruitment procedures were not established. All information specified in Schedule 3 was not available in respect of people employed by the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not planned in a safe way as medicines were not managed safely. The service had not done all that is reasonably practicable to assess and mitigate risks to people's health and safety.

The enforcement action we took:
We issued the provider with a warning notice requesting compliance by 1 December 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of staff had not been deployed by the service. Staff had not received appropriate training and support.

The enforcement action we took:
We issued the provider with a warning notice requesting compliance by 15 November 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not in place to assess, monitor and improve the quality of the service. An accurate and complete record in respect of each service user was not maintained.

The enforcement action we took:
We issued the provider with a warning notice requesting compliance by 1 December 2015.