Festival Care Homes Ltd

Barleycroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 27 and 28 August and 4 September 2015 and was unannounced on 27 August 2015.

Barleycroft is a purpose built 80 bed care home providing accommodation and nursing care for older people, including people living with dementia. There are three separate units. The first provides residential care, the second dementia nursing care and the third general nursing care. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. For example, hoists and adapted baths are available. When we visited 57 people were using the service.

A new manager had started work at the service on the day before the inspection and was therefore not registered. 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 and associated Regulations about how the service is run. The new manager had started the process to cancel their registration at the service they previously managed and to apply to be the registered manager at Barleycroft.

We found that the arrangements for administering medicines were not safe. People were not always

Summary of findings

protected from the risks associated with taking expired medicine. Medicines records were not always accurate and we could not be confident that people received all of their prescribed medicines safely.

People told us they felt safe at Barleycroft and that they were supported by kind, caring staff who supported them with respect. One relative said, “I have peace of mind when I leave that [my relative] is in a safe place. I know they are well looked after.”

The provider’s recruitment process ensured that staff were suitable to work with people who need support.

Systems were in place to ensure that equipment was safe to use and fit for purpose. People lived in a clean, safe environment that was suitable for their needs.

Robust systems were not in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People told us that the food was good and that they had a choice of food and drinks. We saw that people’s nutritional needs were met. If there were concerns about their eating, drinking or weight this was discussed with the GP and support and advice were sought from the relevant healthcare professional. For example, a dietitian.

Staff received the training they needed to provide a safe appropriate service that met people’s needs.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice.

Arrangements were in place to meet people's social and recreational needs. There were mixed views about these. Some people said that they were satisfied with the activities and others told us they would prefer more activities or in some cases more appropriate activities.

Although people’s individual files contained information about their life history, likes, dislikes, and religious beliefs, we found that care plans were not always reviewed each month. They did not give sufficient detail to ensure that people received care and support that fully met their current needs.

The provider had systems in place to monitor the service provided and people were asked for their feedback about the quality of service provided. However internal audits had not been carried out consistently and timely action had not always been taken to address shortfalls.

There had been a number of concerns about the service and the registered provider had taken action to address the issues and improvements were happening.

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?

Not all aspects of the care provided were safe. People were placed at risk because the system for administering and recording medicines was not robust.

Risks were identified and systems put in place to minimise risk in order to ensure that people were supported as safely as possible.

Staff were trained to identify and report any concerns about abuse and neglect. They knew how to respond to emergencies to keep people safe.

The premises and equipment were appropriately maintained to ensure that it was safe and ready for use when needed.

Requires improvement

Is the service effective?

The service was not always effective. Systems were not in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The staff team had the training they needed to ensure that they supported people safely and competently.

People told us that they were happy with the food and drink provided. They were supported by staff to eat and drink sufficient amounts to meet their needs.

People's healthcare needs were identified and monitored and referrals made to other healthcare professionals when needed.

The environment met the needs of the people who used the service.

Requires improvement

Is the service caring?

The service provided was caring. People were treated with kindness and their privacy and dignity were respected.

Staff supported people in a kind and gentle manner. They met people's needs in a friendly and patient way.

People received care and support from staff who knew their likes and preferences.

Staff provided caring support to people at the end of their life and to their families.

Good

Summary of findings

Is the service responsive?

Not all aspects of the care provided were responsive. Care plans were not always reviewed each month and did not give sufficient detail to ensure that people received care and support that fully met their current needs.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for.

Activities, entertainment and trips out were available if people chose to take part in these.

Requires improvement

Is the service well-led?

The service was not consistently well led. A full management team had not been in post since the last comprehensive inspection in October 2014. This resulted in the service not being robustly managed and a number of concerns had been raised.

Internal audits had not been carried out consistently. Timely action had not always been taken to address shortfalls.

The provider had an action plan in place to address concerns and improvements had been identified.

There were systems in place for people to express their opinions and to give feedback about the service provided.

Requires improvement

Barleycroft 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 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 27 and 28 August and 4 September 2015 and was unannounced on 27 August 2015.

The inspection team consisted of three inspectors, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed 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. Before our inspection, we also reviewed the information we held about the service. We contacted the commissioners of the service to obtain their views about the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with eight people who used the service, the manager, the deputy manager, the provider, the regional manager, three nurses, ten care workers, the activities coordinator, the cook, eleven relatives, a healthcare professional and an independent advocate. We looked at ten people's care records and other records relating to the management of the home. This included three staff recruitment records, duty rosters, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

After the visit we received feedback from two local authorities that place people at this service.

Requires improvement

Is the service safe?

Our findings

People who used the service and their relatives told us that they felt safe at Barleycroft. People who were very regular visitors told us they were comfortable with the safety and care provided to their loved ones and with the support from the staff. One relative said, "I have peace of mind when I leave that [my relative] is in a safe place. I know they are well looked after." Another told us, "I think [my relative] is in a very safe place. It's not just me saying this, the family also think it's a safe place".

However, not all aspects of the care provided were safe. We found people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We looked at a sample of Medicines Administration Records (MAR) and found that they included the person's name, their photograph, the type of medicine and dosage, the date and time of administration and the signature of the staff who administered it. In most cases we found the MAR to be accurate. However, we found three instances on the same unit of inaccuracies in the MAR of three separate people. One person had missed a dose of a once-weekly medicine in the seven days prior to our inspection. This was confirmed with a stock-check of the medicine. There was no indication from the documentation why the person had not received this dose and staff could not explain why. For different people two other doses had been recorded as being given and had been signed for but dated the day after our inspection. A senior care worker told us it was an administrative error and had been reported to a member of the management team. There were not any safeguards in place to ensure that staff the next day would be aware of the mistake. Therefore systems were not in place to ensure that people received their prescribed medicines safely and in a timely manner as prescribed by the GP.

The home used a Monitored Dosage System to ensure that medicine was given at the correct time and in the correct quantity. Dosage trays were colour coded to help staff identify the correct time of day to administer the medicine. The details were included on the individual MAR. Some medicines were kept in their original prescription containers. The MAR we checked inconsistently included a stock quantity of some medicines but these were not always accurate. For instance, one person who took two different doses of a medicine depending on the day of the week had their quantity inaccurately recorded. Another person who took medicine from a blister pack that delivered the pills in monthly 28 doses had their current quantity on the MAR indicated as 84. Therefore the service did not consistently follow safe practice around accurate management of medicines for people.

Some medicines, once opened, must be used within a fixed time frame to ensure they are effective. This means that staff should write the opening date clearly on the packaging so that it can be discarded once the expiry date is reached. We found that this practice was not always followed. This meant that people were not always protected from the risks associated with taking expired medicine.

The issues highlighted above evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were kept safely and appropriately stored. Medicines were securely stored in appropriate locked medicines trolleys in locked 'treatment' rooms. The person responsible for the administration of medicines kept the keys with them during their shift. There were also appropriate storage facilities for controlled drugs. The temperature of the medicine storage rooms and medicine fridges were checked and recorded daily. Storage rooms were air-conditioned and we found that the temperature was maintained within the recommended range for medicines to remain effective.

We looked at the provider's guidelines for spoilt medicines and the disposal of medicines. We found that staff were aware of both the guidelines and adhered to them appropriately. Some people received doses of medicine through medicine patches as opposed to tablets. In all but one case staff had consistently followed best practice guidance when administering this, and up to date body maps were kept in the person's MAR. This meant staff could see where the next patch should be placed. In all cases the administration of this medicine had been confirmed with the signature of two members of staff.

Some people received their medicine covertly. This meant that it was given in food or a drink and people were unaware they were taking the medicine. The covert administration of medicine had been approved following best interests decisions made by GPs, nurses and family

Is the service safe?

members as it was deemed necessary for their health and wellbeing. On the day of our inspection, the medicines provider had begun to prepare more detailed directions for nurses, including the specific types of food or drinks that could be used to deliver the medicines. This was to ensure that these medicines were administered appropriately and as safely as possible.

We looked at the documentation relating to the receipt, storage, administration and disposal of controlled drugs (CDs). CDs had been checked on receipt by two staff and stock check records, administration and returns had been double-signed in all cases.

There were clear guidelines in place for the administration of 'when required' medication so that staff were clear as to when and how to administer this.

We observed staff during medicine rounds. We saw that they ensured people had taken their medicine before recording this and leaving them.

Staff were aware of the service's safeguarding policies and procedure in order to protect people from abuse. They were aware of different types of abuse. They knew what to do if they suspected or saw any signs of abuse or neglect. Staff told us that they had received safeguarding adults training and that they reported any concerns to senior staff. The service held monies for some people to pay for hairdressing, chiropody and other small items. We saw that monies were securely stored in individual envelopes and that access was restricted. There was evidence that the provider carried out random audits to check monies held. We checked the monies and records for five people and found that the amount of cash held tallied with the record. Therefore systems were in place to safeguard people from abuse.

We found that risks were identified and systems put in place to minimise risk and to ensure that people were supported as safely as possible. People's files contained risk assessments relevant to their individual needs. For example, falls, malnourishment and the development of pressure ulcers. Individual risk assessments were reviewed by staff each month to ensure that they were up to date.

The premises and equipment were appropriately maintained. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. Gas, electric and water services were also maintained and checked to ensure that they were functioning appropriately and were safe to use. On the first day of our visit we found that some portable appliances had failed the testing. Records did not confirm that action had been taken as a result of this. However the electrical company was contacted straight away and an electrician visited to rectify this. The records also confirmed that weekly checks were carried out on hoists, pressure relieving mattresses, bedrails, and fire alarms to ensure that they were safe to use and in good working order. Systems were in place to ensure that equipment was safe to use and fit for purpose.

A fire risk assessment was in place and regular fire drills, including night drills, were carried out. Staff were aware of the evacuation process and the procedure to follow in an emergency. A fire safety company were booked to review and update the risk assessment. Each member of staff was issued with a health and safety handbook to support them in providing a safe environment and minimising risk. People were cared for in a safe environment. The provider had appropriate systems in place in the event of an emergency.

The provider's recruitment process ensured that staff were suitable to work with people who need support. This included prospective staff completing an application form and attending an interview. We looked at three staff files and found that the necessary checks had been carried out before staff began to work with people. This included proof of identity, two references and evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with people who need support. Nurse's registration with the Nursing and Midwifery Council was also checked to ensure that they were allowed to practise in the United Kingdom. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom.

During the first two days of our inspection we found that there were sufficient staff on duty to meet people's needs. However when we returned to the service to complete the inspection we found that in the residential unit staffing levels had been changed. Staff expressed their concerns about this particularly as some people required the help of two staff for personal care. We discussed this with the manager. They agreed to review the situation and to action

Requires improvement

Is the service safe?

the outcome of their review. They also told us that some people's needs had increased and they would be reassessed to see if they now need to be cared for in one of the nursing units.

Requires improvement

Is the service effective?

Our findings

People we spoke with responded positively about the service and the care provided. A relative told us, "It's really lovely here and the carers couldn't do more for [my relative]. They'll do anything here to help you. Nothing is too much trouble."

However, we found that the service was not always effective. We found that the management of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was not robust. The MCA is legislation to protect people who are unable to make decisions for themselves and DoLS is where a person can be lawfully deprived of their liberty where it is deemed to be in their best interests or for their own safety.

Records showed that although most staff had received MCA and DoLS training this had not been 'refreshed' or updated and one member of staff told us that they did not know what this was. Staff were clear that people had the right to and should make their own choices as far as possible. People told us that they were encouraged to do this. One person told us that staff asked their consent before carrying out any tasks and that they were not forced to do anything they did not want to. A relative said, "I think the choice they get is really good." However, staff had a limited understanding of the MCA and DoLS. The clinical staff and the management team were more aware of this and of the need to obtain best interests decisions and to apply for DoLS authorisation from the relevant supervisory bodies. Records confirmed that when necessary applications for DoLS had been made to ensure that people were not being unnecessarily or unlawfully deprived of their liberty.

For some people with DoLS in place these had been agreed, by the relevant supervisory body, subject to certain conditions. Although the nurse was able to tell us about action taken, for example supervised visits, there were no specific plans in place to meet the conditions and no evidence to show that these conditions had been complied with. In the files we looked at we saw resuscitation decision forms. In some cases mental capacity assessments had been carried out and there was a note of 'best interest' discussions. However they had not been properly completed. They did not always indicate if the person had mental capacity or if the person and their family agreed with the decision made. In addition there was no evidence to confirm that relatives had the necessary legal right to consent to the decisions being made. The registered person did not have robust systems in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The issues above evidence a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with a choice of suitable nutritious food and drink. The chef told us that a four week menu was provided by the organisation's head office but that she reviewed this and made changes based on her knowledge of peoples likes and dislikes and from feedback they had given her. The chef confirmed that most food was homemade and that the service was able to cater for a variety of dietary needs. For example, diabetic, gluten free and Halal. Therefore people were able to have meals that met their cultural, religious and health needs. We looked at the menu and saw there was a choice of main meals each day plus a selection of alternatives that were always available. People chose their main meal the day before but could change their mind at any time. For example, some people did not want the fruit crumble and had ice cream instead. People told us that they were happy with the choice and quality of meals provided. A relative told us, "It's really lovely here. [My relative] has put on weight since she's been here. The food is nice. It's not sloppy food, it's the sort of meal you would cook at home". A person who used the service said, "I'm well looked after here, the food is good and there are no problems". People told us how nice the chef was.

People were supported to be able to eat and drink sufficient amounts to meet their needs. We saw that people had water or squash at their side and had regular tea and coffee breaks during the day. Fruit and biscuits were also available. Some people ate independently and others needed assistance from staff. We observed that staff appropriately supported people to eat and that they were not hurried. We saw that some people required a pureed diet and each food was pureed and served separately to enable them to enjoy the different tastes. On the first day of the visit we found that in one unit the dining room had been made a comfortable and welcoming place to eat. The tables had been laid with double linen table cloths, drinking glasses with serviettes placed inside and cutlery. The menu was displayed on each table. This was not the case in the other units. Tables were not laid, menus were

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not on tables and there were plastic beakers for drinks. We raised this with the manager. When we returned the next week to complete the inspection we found that this had been discussed with staff and more glasses and serviettes were ordered. We saw that the tables were nicely laid in each unit. This meant that the dining rooms were a more homely and welcoming place for people to have their meals.

Staff recorded what people had eaten and drunk and how much. When there were concerns about a person's weight or dietary intake we saw that advice was sought from the relevant healthcare professionals.

We saw that the GP visited weekly and that opticians, podiatrists and dentists also reviewed people regularly. The GP told us that the nurses were good and if they had any doubts about a person's health they called the doctor. They also told us that staff followed instructions and checked people regularly. People were positive about the support they received to meet their health needs. Although people's healthcare needs were monitored and addressed to ensure that they remained as healthy as possible this had not been consistent. Prior to the inspection some relatives had raised concerns with the service, the local authority and CQC about how people's healthcare needs had been met. We saw that the provider had responded to these concerns and an action plan was in place to address the issues and to ensure that people's healthcare needs were effectively met.

The environment met the needs of the people who used the service. There was a lift and the building was accessible for people with mobility difficulties. There were adapted baths and showers and specialised equipment such as hoists were available and used when needed. We saw that the environment was designed to meet the needs of the people who used the service and was accessible throughout for people with mobility difficulties. Adapted baths and showers were available on all floors and specialised equipment such as hoists were readily available and used when needed. In line with guidance toilet door frames had been painted yellow and red toilet seats had been fitted to help people living with dementia to more easily identify these areas.

Staff told us that they had received the necessary training to enable them to effectively care for people. This included induction when they first started working at Barleycroft and ongoing regular training. This included manual handling, fire safety, infection control, safeguarding, dementia awareness, Deprivation of Liberty Safeguards and the Mental Capacity Act. They told us it was the right training for the job that they did and that it was a mixture of e-learning and face to face training. In addition to qualified nurses people were supported by staff who had already obtained or were in the process of obtaining health and social care qualifications in care. One member of staff told us that they had just completed a level three qualification in health and social care and had chosen the modules most relevant to the service. A unit lead told us that they were doing a level five management course. People were supported by staff who received the training needed for them to develop the necessary skills and knowledge to meet their assessed needs, preferences and choices.

We found that some staff had been appropriately supported in their roles through individual supervision meetings with their line manager to discuss work practice and any issues affecting people who used the service. For other staff the individual supervision had been very limited. However staff said that they did receive less structured support from unit leads, nurses and the deputy manager. The new manager had already identified the gaps in supervision and was in the process of putting a supervision schedule in place to address this.

Good

Is the service caring?

Our findings

The service was caring. People were positive about the care and support they received. They told us that staff were kind, caring and respectful. One person said, "The staff are very nice. One just brought me a coffee. I did not even have to buzz. She (staff) gave me a mug as she knows I like that."

People's privacy and dignity were maintained. We saw that staff knocked before going into people's rooms. Staff told us that they took people to their rooms and closed curtains when providing personal care. They said they respected people's wishes if they wanted same gender support. One member of staff said, "One resident does not like male carers so female staff always support her."

We observed that staff supported people in a kind and gentle manner and responded to them in a friendly and patient way. For example, at lunchtime one person became very agitated and did not want to eat. The nurse sat with the person, spoke to them calmly and gently for a few minutes and the person calmed down and went on to eat. Throughout the visit we saw the staff talking to people, they smiled, made eye contact and allowed time for the person to reply. We also saw that staff discreetly explained to people that they were going to assist them with their personal care needs.

Although there had been some new staff in post recently the staff we spoke with knew the people they cared for.

They told us about people's personal preferences and interests and how they supported them. One relative said, "Really, the staff are brilliant. It's lovely to see [our relative] is well looked after. Another told us, "[My relative] can't get out of bed. She has really nice carers, especially the two male carers who look after her. They know her very well."

People were supported by staff to make daily decisions about their care as far as possible. We saw that people made choices about what they did, where they spent their time and what they ate. A member of staff told us, "We ask what they want to wear and do. For example, the music man was here today so we asked if people wanted to go and listen. Four people went."

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice. The hospice provided staff training in end of life care and four nurses had been specifically trained to administer pain relieving medicines to help people to remain pain free and be as comfortable as possible at the end of their life. We saw thank you notes from bereaved relatives. One had written, "Thank you for your care particularly in [my relative's] last days." A healthcare professional told us that end of life care had improved and that they were working proactively with the staff team to improve the quality of the end of life care further. People benefitted from the support of a caring staff team.

Requires improvement

Is the service responsive?

Our findings

Not all aspects of the care provided were responsive. People's individual records showed that a pre-admission assessment had been carried out before they moved to the service. They had life stories and personalised daily routines. We found these to be very specific and they contained information about people's life history, likes, dislikes, and religious beliefs. However we also found that care plans were not always reviewed each month and did not always give sufficient detail to ensure that people received care and support that fully met their current needs. For example, one person's medicines and pain management care plan had last been updated in May 2014 and stated that they readily took their medicine. However we also saw that this person's medicines were now administered covertly (in food without them knowing) due to their continual refusal to take them. For another person their care plan covering one aspect of their care contained information stating that they were able to weight bear and stand for transfers. However in a care plan covering another area of care it stated that the person needed the assistance of two staff and needed to use a hoist. For a third person their care plan stated, "Ensure I have adequate fluids." However there was no detail in their care plan as to what this meant for the person. This placed people at risk of receiving inconsistent care that did not safely meet their needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were referred appropriately for input by specialists such as speech and language therapists and dietitians. Senior staff were clear about the process to follow to obtain specialist input but one did comment that they had to wait longer for a visit than previously. The GP did a weekly 'round' at the service and staff told us, "People are checked regularly." Systems were in place to identify and address people's healthcare needs and to support them to receive the healthcare they needed.

Changes in people's care needs were communicated to staff during the handover between shifts. In one unit staff told us that people had 'communication' books in their rooms for relatives to write in with any comments or things that they wanted staff to know.

People who used the service and their relatives were positive about the way the staff responded to their needs. One relative said, "I'm very pleased at how [my relative] is being looked after. The staff here are brilliant, couldn't do more for you." Another added, "If I mention anything they're onto it straightaway." A person who used the service told us, "The staff are very nice. They help me."

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. A member of staff told us, "We ask residents what they want. What they want to do, to wear, if they want a shower or a bath. Today four people chose to go downstairs to the music man. Recently people went to Southend but one person said no so did not go."

Arrangements were in place to meet people's social and recreational needs. Two activity workers were in post to support this. We saw that activities were offered within the service and that on occasions people went out in the community with the staff. We saw that some people had recently visited some lavender fields. One person told us that they had really enjoyed the visit. On one of the days we visited there was a 'music for the brain' session and other outside entertainers also visited. Celebrations were organised and relatives joined these. In house activities included sensory games, reminiscence, musical bingo and exercises. A relative told us, "The activities lady is really good, and when there's something on downstairs she comes up and takes [my relative] downstairs to join in. She knows that [my relative] needs some stimulation".

Although we could see that activities, outings and entertainment were arranged there were once again mixed views about these. Some people said that they were satisfied with the activities and others told us they would prefer more activities or in some cases more appropriate activities. One person told us they were bored and a relative said, "There's always something going on. There's a trip out to Southend next week".

There was guidance about how to make a complaint which was displayed around the service. We looked at the complaints file and saw that formal complaints had been dealt with in line with the provider's policy and people had received a written response from the manager. Other complaints were dealt with by senior staff in the units. People told us that they knew who to talk to if they were not happy about anything. Quarterly relatives meetings were held and this also gave people an opportunity to give feedback about the service and any concerns they might have.

Requires improvement

Is the service well-led?

Our findings

The service had not been consistently well led. There was not a registered manager in post. The manager in post at the time of the inspection in October 2014 left the service shortly after. The provider began recruitment straightaway and an acting manager was in post. Unfortunately there was an unavoidable delay in the recruitment and the new manager had started work at Barleycroft on the day before this inspection.

Systems were in place to monitor the quality of service provided. A provider visit was carried out on a monthly basis and a report written indicating who they had spoken to, what they had looked at and their findings. Completed audits, accident reports, complaints and other issues were recorded on a shared drive and senior managers of the organisation monitored these. However, the internal audits had not been carried out consistently and timely action had not always been taken to address shortfalls. For example, medicines audits should have been conducted on a monthly basis but this was not consistent across the service. In June and July 2015, only one unit had been included in each audit. Where an audit had highlighted shortcomings appropriate action had not always been taken. For instance, in an audit that had taken place on July 5 2015, we found that corrective action was missing in some cases. The audit found shortcomings in the documentation of medicine doses, the dating of fixed-life products and in the double-signing of certain medicines but there was no evidence that these issues had been followed up. Improvements were needed to ensure that robust and effective systems were in place to monitor the service so that people received a service that was safe, effective and responsive to their needs. This was in breach of regulation 17 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sought feedback from people who used the service and stakeholders by means of an annual quality assurance questionnaire. The regional manager told us that responses from this were analysed and an action plan put in place to respond to any issues that had arisen. However the outcome of the surveys was not available at the service. The provider sent us an analysis of the staff survey but was unable to provide information about the responses from relatives and people who used the service. We were however provided with a copy of the action plan that was put in place to address the issues raised in the surveys and from concerns. In addition people's opinions were sought at 'residents' and at relatives meetings. At the relatives meeting in July 2015 recruitment, local authority concerns and maintenance had been discussed. We saw that the provider had been open with people with regard to the actions taken by the local authority as a result of concerns. In resident meeting minutes we saw that people had been asked about meals, activities, trips they wanted to do and to feedback on events that had already happened. People used a service where they were listened to and their views were taken into account when changes to the service were being considered.

There were clear management and reporting structures. There was a manager and a deputy in overall charge of the service. In addition to care workers and nurses, there were unit leaders and senior care workers on each floor. However, the management team had not been complete since the previous manager left. In addition to the managers vacancy the unit lead post for one of the nursing units had been vacant for some of the time. The new lead started work in the middle of August. The outcome of this had been that the service had not been robustly managed. There had been a number of staff vacancies and high levels of sickness and absences. This resulted in a high dependency on agency staff and people did not receive consistent support from staff that they knew and who were fully aware of their needs.

Staff, relatives and people who used the service raised a number of concerns that were investigated by the local authority and the provider. An action plan was put in place and the regional manager increased their level of involvement to provide additional support to the service and to carry out some of the management tasks. Improvements had been noted by the local authority, relatives and staff. This included the use of agency staff having been reduced from an average of 250 hours per week to just 36 hours. One member of staff said, "The service is coming up again, everyone is on their toes." Another told us, "We are somewhere in the middle. It did go down but is coming back up. Everyone is more aware now." A third added, "I'm happy now. Things are moving in the right direction."

When we completed this inspection the new manager had only been in post for two weeks but staff were already speaking positively about his actions. One member of staff

Requires improvement

Is the service well-led?

told us, “The new manager is straight and clear about what he wants. He is on the ball and I think the service will settle and get better.” Another said, “We have had a staff meeting and he has told us what he wants to do. It will help.”

Daily short meetings were held with the manager, deputy, the leads of each unit and of ancillary services. At this meeting information was shared about issues, what was happening in each unit and what was happening with regard to ancillary services. The manager also checked that staffing was satisfactory on each unit. This ensured that the management team were aware of the current situation in the home and of any issues affecting people who used the service and that they were able to respond in a timely manner. We attended two of these meetings and found that the manager was clear about what needed to be done. He told those present that information from the meeting needed to be shared who all staff and that if they worked together as a team they could address the issues. Systems were in place to ensure that the management team were made aware of issues affecting people who used the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have robust systems in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Regulation 11 (1) & (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not adequately assess, monitor and improve the quality and safety of the services provided .Regulation 17 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The lack of current and specific information about people's needs placed them at risk of not consistently receiving the care that they required. Regulation 9 (1) (a) & (b).