Claremont Care Limited

Elmhurst Nursing 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was carried out on 5, 6 and 11 April 2016 and was unannounced.

Elmhurst Nursing Home is registered to provide accommodation with nursing care for up to a maximum of 37 people. There were 30 people living at the home during our inspection and some people were living with dementia.

There was no registered manager in post. The service is required to have a registered manager. There was a temporary manager in post who was present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection 10 February 2015 the service was given an overall rating of requires improvement. We found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The breach related to not enough staff being on duty at night. This meant people did not get the care and supported they required when they needed it. We asked the provider to make improvements and to send us an action plan of how they intended to address the shortfalls in care.

The previous provider went into administration on 3 February 2016 and a temporary provider had been brought in to manage the service on behalf of the administrators. A temporary manager was appointed and had been in post eight days on the first day of our inspection. The provider and manager had completed a number of checks and had found a number of improvements were required to ensure people's safety and wellbeing. They had a clear vision for the service and were keen to address the identified risk. They had secured additional management resources to bring about timely change and improvement.

At this inspection we found that there were still concerns about the level and deployment of suitably trained staff. People told us they often had to wait for support and this sometimes compromised their dignity. Staff felt overwhelmed by their workloads and frustrated that they did not have time to spend with people other than when they were assisting them with personal care and meals.

Some people did not receive their medicine as prescribed as staff had to prioritise the needs of people who required their medicines at specific times. The morning medicine round often did not finish until late morning and this affected when people could be given their next medicine. Some people's medicine records were inaccurate and did not reflect the treatment staff were giving to them.

People were cared for by staff who did not have consistent support and supervision to undertake their roles. Staff did not have the appropriate training to enable them to understand and support people living with dementia or other specific illnesses. Staff felt communication was poor and did not feel listened to or supported by the provider.

People's ability to make their own decisions had not been appropriately assessed. Where decisions had been made on people's behalf there were no records to show why these decisions were in their best interests. People were always asked before support was given and their wishes were respected. We saw that people were given choice about day to day decisions such as what they would like to wear and where they would like to sit.
People were not always involved in decisions about their care and treatment. People's care plans were not always tailored to their individual needs and had not been reviewed.

People's nutritional needs had been properly assessed and monitored. Where people had lost weight they had been referred to the doctor to establish why. People were offered a choice of what they wanted to eat and drink.

People were supported by staff who knew how to keep them safe and how to report concerns should they witness or become aware of abuse taking place. Staff were aware of the support people needed to reduce the risk of harm. Staff knew how to deal with accident and incidents and there were systems in place to reduce the risk of reoccurrence. Appropriate checks had been made to ensure that staff were suitable to work at the home. Staff received a structured induction to ensure that they were competent and confident to support people safely

People were treated with kindness and compassion. Staff had good working relationships with people. They were aware of their likes and dislikes and how they preferred their care and support to be provided. People were treated with dignity and respect and were supported to remain as independent as possible.

People and their relatives were happy to speak to management if they had any concerns or complaints. Where people had complained their concerns had been dealt with appropriately. The provider did not have an up to date complaints procedure. The provider did not have system for gathering people's opinions on the development of the service.

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?

Requires Improvement

The service was not safe.

People did not always get the support they needed because staff were not deployed effectively to meet people's needs. Staff knew how to protect people from harm and abuse and who to report concerns to. People did not always get their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not effective.

People were cared for by staff who did not have consistent supervision and training to undertake their roles. People's ability to make decisions about their own care and treatment had not been appropriately assessed. Staff sought people's consent before supporting them. People's nutritional needs had been assessed and monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in decisions about their care and treatment. Staff did not always respect people's belongings or private space. People and their relatives felt staff were kind and considerate. Staff had built positive relationships with people. Staff promoted people's independence and offered them choice.

Is the service responsive?

Requires Improvement

The service was not responsive.
People's needs had not been kept under regular review and care plans were not reflective of their needs or circumstances. People did not receive adequate stimulation to promote their emotional wellbeing. People told us if they had any concerns they would raise these with staff or the manager. The provider did not have a complaints procedure in place but were seen to deal with complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led

There was no registered manager. A temporary manager was in post who had a clear vision for the service. They were keen to make improvements to ensure people's safety and wellbeing. The provider had introduced a number of checks to monitor the service and identified where improvements were required. Staff felt communication was poor and did not feel listened to.

Elmhurst Nursing 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 5, 6 and 11 April 2016 and was unannounced. The inspection was conducted by two inspectors.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We used this information to plan the inspection.

The previous provider Claremont Care Limited went into administration on 3 February 2016. The administrators of the home have employed a temporary provider to manage the service on their behalf. Prior to the inspection we had received a number of concerns from members of the public and the local authority safeguarding team. These related to concerns about the quality of care, staffing levels and poor record keeping at the home.

During the inspection we spoke with 13 people who used the service and six relatives. We spoke with 22 staff which included the interim manager, the regional manager, three nurses, 13 care staff, the activities worker, one office staff and two kitchen staff. We also spoke with a visiting hairdresser. We viewed nine records which related to assessment of needs and risk. We also viewed other records which related to management of the service such as medicine records, accidents reports and recruitment records.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is specific way of observing care to help us understand the experience of people who were unable to talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection the provider was not adhering to their own dependency assessment tool and did not provide enough staff to meet people's needs. The provider sent an action plan which told us they had increased the amount of staffing at night. Prior to the inspection we had received concerns about staffing levels and the high use of agency staff at the home. At this inspection we found that there were continued concerns about staffing levels at the home.

People, relatives and staff we spoke with felt that there were not always enough staff to meet people's needs. One person told us they often had to wait for support and there been occasions when they had been inadvertently incontinent. They said this was because staff had taken too long to respond to their call bell. A relative told us staff were always rushing around and the call bells were constantly ringing but felt that staff tried their best. During our inspection we saw that staff responded quickly to call bells and people's requests for support. However, on the second day of our visit a member of staff was unable to attend their shift and cover could not be found for the morning shift. It was noted that less people had got up on this day. When we discussed this with staff, one staff member said that this was because there were not enough staff on duty that day. Staff told us they often worked with agency staff and recognised the need to support these workers to ensure they supported people safely. However, they felt that this sometimes impacted on their ability to carry out their role effectively as this took time and added to the pressure of their roles. They went on to explain that agencies were now providing regular staff which was reducing the pressure on them.

All the nursing staff we spoke with felt that there was too much work for one nurse on the morning shift. There was only one nurse on each shift apart from two shifts when the clinical lead nurse was given dedicated time to perform their clinical role. They felt that medicine rounds took up most the morning and by the time they had completed this and saw to people's skin care it was time to do the lunch time medicines. They told us this left them little time to review people's needs to ensure they were getting the right care and treatment. One nurse told us they were very experienced and felt that someone with less experience would 'drown' with the level of work and responsibility expected of them by the provider.

The manager told us there had been ongoing staffing problems. There was only one permanent nurse working at the home and the rest of the nursing shifts were being covered by agency. In order to promote consistent support for people living at the home they had met with the agencies to secure the same appropriately skilled staff on a regular basis.

The provider did not have an effective system for determining the number of staff they needed on duty to meet the needs of the people using the service. They were in the process of making sure that each person's needs were assessed to give them an accurate record of their level of need and the staffing levels required to meet them.

This is breach of Regulation 18 HSCA 2008(Regulated Activities) Regulations 2014.

People were not given their medicines as they had been prescribed. One person told us, "I had my breakfast

at 8 o'clock, it is a long time to wait for my tablets". Medicine was only administered by the qualified nursing staff. We saw that medicine rounds were not completed until late morning on each day of the inspection. The nurses told us this was due to their workload and they had to prioritise people who were on medicine that needed to be taken at a specific time. They explained because it took so long to complete the medicine round they had to consider when some people could have subsequent doses of their medicine. This was because they had to ensure there was sufficient gaps between doses. As a result they constantly had to keep going around the home rather than having an organised routine

We saw that people's medicine records were inaccurate and did not reflect the treatment staff were giving to them. For instance, one person's record showed they needed two creams applied to their skin but staff confirmed they were no longer applying either of these. A staff member explained they were applying a different cream but thought this was not prescribed and therefore were not recording it had been applied. There was a prescription label on the cream and a nurse confirmed that the cream had been prescribed for the person. They told us that the manager was in the process of reviewing all the charts in people's rooms. We also found that one nurse had made the decision not to give a person their prescribed medicine because there was a signature missing off the medicine label. They did this without consulting with the doctor about omitting this medicine. This had no impact on the person on this occasion but potentially could have affected the management of the person's health condition. It is important to seek medical advice when omitting people's medicines as they may be placed at risk of harm if they do not receive the medicines that they have been prescribed to them. The manager told us they had identified a number of areas that needed improvement. These included introducing a number of changes to make sure that people were given their medicines as they had been prescribed. Where required we saw that the new provider had taken appropriate action to deal with areas of poor practice.

This was a breach of regulation12 HSCA 2008(Regulated Activities) Regulations 2014.

We looked at how the provider monitored and reviewed the safety of the environment to ensure risks to people were reduced. The regional manager told us they had employed an outside agency to review the health and safety risks assessments for the home. In the meantime they completed monthly health and safety checks and reported these to maintenance to carry out any necessary repairs. We saw that the provider had completed personal evacuation plans for people should they need to vacate the home in the event of a fire or any other emergency.

Two people told us they sometimes felt discomfort when staff moved them. Only staff who received training to move people safely did so. Staff were aware of the risks associated with people's mobility and knew what equipment and how many people were required to move people safely. During our visit we saw that staff used equipment safely and competently to help people move around the home. Staff understood that people who were less mobile were at risk of pressure areas developing. They monitored people's skin care when providing personal care and told us they would report any concerns to the nurse. We saw that skin care and repositioning charts were in place to promote good skin care. However, we saw that repositioning charts were not always completed at the required frequency.

When asked whether they felt safe living at the home one person told us, "I have no worries about anything, staff are lovely and I feel very safe and looked after". Another person said, "I suppose I'm as safe as I can be". Not all the staff we spoke with had received training on how to keep people safe but knew about the different types of abuse and how to report concerns. When asked what they would do if they witnessed abusive practice one staff member said, "I would always report it to the nurse if I was worried". The manager was aware of their responsibility to report concerns of abuse to the local authority. We saw that they had liaised with the local authority about recent concerns and had taken actions to address the concerns raised.

The provider had recorded that they had sent us two statutory notifications for safeguarding incidents in February. However we had not received copies of these notifications and they were unable to find copies. We were therefore unable to establish the nature of the incidents or outcomes of any action that may have been taken.

Prior to the inspection we had received concerns the provider was not following safe recruitment procedures for new staff. We found the provider was in the process of updating their recruitment process. We looked at the records of two potential new staff and saw that the provider was completing checks to ensure that they were suitable and safe to work at the home. These included references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable employees from working with people. We also viewed the records of member of staff who had worked at the home for several years and found that all relevant checks had been completed. New staff we spoke with confirmed that they had been asked to provide references and complete DBS checks prior to starting to work at the home.

Staff were aware of their responsibility to report accidents and incidents. They told us they would ring the emergency bell and stay with the person until the nurse or manager arrived. The manager had oversight of the completed forms and analysed these to establish what action was required to prevent reoccurrence. For example following a recent incident with medicine, new systems and training had been arranged to reduce the risk of this recurring. The manager also kept an overview of the incidents to identify if there were any or patterns or trends.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that the provider had assessed everybody in the same way and had not taken an individualised approach to determining people's capacity to make decisions about care and treatment. We saw that capacity assessments had been completed for people who had the capacity to make decisions for themselves. One MCA assessment we looked at said the person, "Had no issues with memory they are able to consent to care and treatment". This demonstrated a lack of understanding in regards to the principles of the MCA. We also found that relatives had signed people's consent to care forms as well as consent to people having the flu vaccination without having the legal authority to do so. We could not be assured that people's human right were protected or that decisions made on their behalf had been made in their best interest. However on a day to day basis people told us staff gave them choices and asked if they were happy for them to help. For example, one person explained that one staff member always asked, "May I?" before they supported them. Another person told us that staff asked them how they would like things done. Staff told us they sought people's permission before supporting them. One staff member said, "I always ask people what they want to do and if we can to things".

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us they had been unable to find a record of DoLS applications made. They had contacted the local authority to determine the status of DoLS for people living at the home. However, they did not have copies of the authorisations and were not aware of any conditions which may have been attached to them. Therefore they could not assure us these were being met or that the least restrictive measures had been taken to deprive people of their liberty. The DoL applications we looked at did not specify what the DoL application was in relation to and this was not documented in the people's care records. Not all staff had received training in MCA or DoLs and had a limited understanding of the DoLS process and what this meant for people and their practice.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received regular supervision. Supervisions are one to one meetings with a senior member of staff who provide guidance and support to staff to enable them to fulfil their role. One staff member told us they had not had supervision for nearly a year. Some staff we spoke with had not received training in relation to the management of specific illnesses or diseases that people at the home lived with. These included dementia, epilepsy and multiple sclerosis. One person said, "I feel sorry for the staff because I have brought an illness to the home that they are not used to". One staff member told us they wanted to learn

how to care for people living with dementia as they felt that they could be better at how they reacted to people when they were upset. Another staff member told us they had received very little training about dementia. They said, "We need to be able to understand why people [living with dementia] act as they do". They explained that training would give them a better understanding of people's experience and how best to support them. New staff told us they were given an induction when they started. This included working alongside more experienced staff until they felt competent and confident to support people safely.

People and their relatives had different opinions about the quality of the food provided. One relative thought the food was ok but institutionalised they said, "The tea yesterday was a plate of 'brown slop'. It looked awful and they [family member] would not eat it". Another person felt that they were fed quite well apart from breakfast they had received that day. They showed us the bacon they had been given for breakfast they said it was hard. They said, "The birds would not even eat it". Other people we spoke with felt that the food was good. The kitchen staff were given a copy of people's dietary profile when they came in to the home and were kept informed of any changes by staff. They were aware of people's nutritional needs and knew people's likes and dislikes. The activities person would speak with people about what they would like to be included in the menus. Menus were also discussed at meetings held at the home. They told us that if people did not like what was on the menu they would make them an alternative. People told us and we saw they were offered snacks and drinks during the day and we saw people who were in their rooms had jugs of drink available to them. Where people required support to eat and drink we saw staff provided this in patient and dignified manner.

People's nutritional needs had been assessed and monitored. However, we found that protocols had not always been followed. For example, where one person had lost weight it was unclear what, if any action had been taken. When we discussed this with the manager they told us they were in the process or reviewing people's nutritional needs and the systems required to monitor them. Where they had identified that a person had recently lost weight they had referred them to the doctor to establish the reason for this.

People told us if they felt unwell or wanted to see the doctor they would tell staff and they would arrange for them to be seen. Staff told us they would tell the nurse if they had any concerns about people's health. The nurse in turn would determine whether the concern was urgent or whether the person could be seen on the doctor's weekly visit to the home. Records of the doctor's visits and the outcome were recorded in the doctor's visit book. We saw do not attempt resuscitation cardiopulmonary resuscitation (DNACPR) orders in some records we viewed. There was also a list of people who had DNACPR orders in place in the nurses office, however the manager stated this required updating.

Requires Improvement

Is the service caring?

Our findings

People were not always involved in decisions about their care and treatment. The manager told us there had been a significant deterioration in one person's health and they were considered to require 'end of life' care. When we looked at this persons care records we saw their care plan had not been reviewed to reflect the changes or to establish the persons' wishes. On discussions with staff we found that not all of them had been told about the changes in this person's needs. When we spoke with the manager who told us they had asked staff to complete this. They took immediate action to review the person's needs.

We saw that two pieces of lifting equipment and a weighing chair were stored in a person's bedroom. When asked staff told the regional manager these were stored in the person's bedroom as there was nowhere else to store them. This showed a lack of respect for the person's privacy and belongings. The regional manager told us they would take action to ensure that staff did not store equipment in people's rooms.

The majority of people we spoke with were positive about the support provided by staff. One person told us, "I think staff perform very good". Another person said, "They're (staff) alright they look after you very well". A relative we spoke with found the care their family member had received while living at the home was exemplary and said the, "End of life care was excellent".

People told us staff were considerate and kind. One person said, "They (staff) are lovely, they are very nice – I don't have any problems – they are always very pleasant". Another person said, "Staff are very adaptable to my needs and are very nice". People were supported to keep in touch with friends and relatives who were important to them. We saw many visitors during our inspection some spent time in the lounge whilst others saw their family members in their room. A relative we spoke with told us, "The staff are wonderful nothing is too much trouble". They explained that their family member had recently passed away they said, "They (family member) were completely cared for, so was I, all the family were supported".

Staff had formed positive relationships with people. One person told us, "Everyone really looks after me". Another person said, "Some staff take more of a family type interest in me". They explained they treated them as if they were family and were 'lovely'. This was confirmed by a staff member who said, "I look at people as if they were a member of my own family and treat them as so". Another staff member stressed the importance of remaining positive they said, "Doesn't matter how I'm feeling, I put a smile on my face" they felt this helped them build a good rapport with people. We saw friendly conversation between people and staff there was some laughter and smiles as people joked with staff. Although busy we saw staff took time to answer people's questions and to reassure people when they were worried or anxious. We heard one staff member reassure someone who had become anxious as they could not remember. The staff member said "Don't' worry I get my days mixed up too you know". The person responded positively to the calm and sensitive approach of the staff member and chatted with them as they carried on with what they were doing.

People told us that staff gave them choices and felt they listened to them. One person said, "They (staff) are very good they will ask if there is anything I want they (staff) go and fetch it for me". Another person told us, "You can please yourself what you want to wear". We saw that people were offered choices, such as what they wanted to eat or drink or where they would like to sit. Staff recognised the diverse backgrounds of people living at the home and respected their differences and preferences. This was confirmed by one person who told us, "I like the women to support me. I don't have any men". Another person said, "I help myself as much as I can and they let me. They are very good and if you want them they are there for you".

People felt staff treated them with dignity and respect. One person said, "They (staff) try very hard to treat me with dignity and preserve my dignity". Another person told us staff always covered them when they had finished washing them. Staff were mindful of people's dignity. One staff member said, "We all try to make sure we preserve their dignity by knocking on doors, covering people up and not exposing them". Another staff member told us they treated people as they would want to be treated. We saw that staff spoke to people in a kind and respectful manner.

Requires Improvement

Is the service responsive?

Our findings

The manager told us and we found that care plans had not been regularly reviewed and did not present an accurate record of people's needs or circumstances. For example, one person's care plan referred to catheter care but they no longer had a catheter. Another person's care plan stated they were widowed however we found their spouse visited on a regular basis. We also found that some care plans were not person centred and had other people's names written on them.

One person was waiting to be assessed to determine if they could get out of bed and sit in a chair. A staff member told us "[Person's name] can't get out of bed until a risk assessment has been done. A nurse said a very long while ago that it needed to be done for their balance and posture – they are now very poorly so won't be getting out of bed anyway". Another staff member told us people were being nursed in bed due to the shortage of time to get everyone up and lack of suitable safe seating. When we spoke with a nurse they told us a number of people had been referred to the physiotherapist to assess their sitting balance. The manager told us they were in the process of reassessing everyone's care needs. They were collecting information from people, their relatives and staff and were using new documents which promoted person centred care.

One person told us, "Staff know me – they know I can have off days, there is more of a problem if they are agency as they don't get told my requirements". They explained they were once supported by two agency staff who were going to get them out onto the toilet and they had to tell they could not because they had no sitting balance. Staff told us there had been a high turnover of agency staff but the agencies were now providing more regular staff who were familiar with people's needs. Staff said they could refer to people's care plans but had limited time to do so. They were given information about people's needs at staff handover meetings. Some staff we spoke with felt that handovers were brief and that the information given did not always represent what they found when they went to help people. For example, one staff member said they could be told someone was 'fine' or 'ok' but when they had gone to the person's bedroom to support them they found they were not at all well. Staff explained that they relied on other staff or the manager if they needed to know anything about people's needs. One staff said, "We all work together to support each other to get it right". The manager told us they were reviewing the current handovers procedures and in the meantime were encouraging staff to speak out if they were unclear about anything.

During our inspection we spent time talking with people and spent time in various parts of the home. Some people chose to remain in their rooms as they preferred their own company. However, others were confined to their rooms due to their physical frailty. One person said, "The only thing here is you have no company – on your own stuck in your room – don't see anyone – cut off from society". When we spoke with staff they told us their time with people was task orientated in order to meet everyone's basic care needs. They explained they had little opportunity to spend time with people apart from when they were assisting them with essential tasks such as personal care or helping them to eat or drink. One staff member said, "It would be lovely to just sit and chat, to make people feel important but we do not have the time, we all try to make them feel special when giving care". Staff told us they liked getting to know about people's pasts and interests. They were able to demonstrate that they knew people personally and were aware of their

preferences.

This is breach of Regulation 9 HSCA 2008(Regulated Activities) Regulations 2014.

The provider employed an activities worker to support people to take part in activities they enjoyed. On the first two days of our inspection the activities worker was on leave and there were no organised activities for people to take part in. People did not receive adequate stimulation to promote their emotional wellbeing. People sat in the lounge were seen to be watching television, looking into the room or sleeping. Some people had dolls they held and spent time talking to. We spoke with people about what they would like to do. One person we spoke told us they were no longer able to do things they used to enjoy doing such as, reading or sewing due to their failing eyesight. They therefore chose not to take part in activities and preferred to watch other people doing them instead. Another person told us entertainers sometimes came in which they enjoyed. On the second day of our visit the hairdresser visited and people took the opportunity to have their hair done. On the third day of our inspection we saw that the activities worker had returned to work and was supporting people with their nail care. The activity worker told us they had found the new provider supportive they said, "If I need something then they will get it for me, they are open to my thoughts as what to do for people". They told us they did a range of activities with people such as board games, cooking, crafts and quizzes. They shared their time between people in the lounge and those who remained in their rooms. However, when they were on leave or away from work no cover was provided. When we discussed this with the manager they told us they were going to arrange extra support for activities.

One person said, "I've never had cause to complain but would tell staff if I had any concerns". Another person told us, "Staff are good, no complaints". People and their relatives told us if they had any concerns or complaints they would report these to staff or the manager. One relative told us they had complained about staffing levels to the previous provider but had been told there was enough staff for the amount of people living at the home. The relative felt this was wrong, they said, "I think it should not be down to numbers, it should be quantified by level of need". The regional manager told us the previous provider's complaint process was out of date and they were in the process of reviewing this. We saw that complaints received by the current manager had been dealt with in an appropriate manner.

Requires Improvement

Is the service well-led?

Our findings

The temporary provider took over management of the home on the 2 February 2016. Initially the home continued to be run by existing staff with support of the new provider's senior managers. The provider had since brought in one of their own manager's to run the home. This manager had been in post for eight days on the first day of our inspection. They showed us an action plan they had been given by the provider. The new provider had identified a number of areas that required improvement.

The provider and manager had subsequently introduced a number of weekly and monthly checks to monitor the quality and safety of the service. Their checks had identified concerns in a number of areas. These included concerns about the management of medicines. A medicine audit completed on the 24 March 2016 had identified a number of concerns. These included an excess of 53 gaps on medicine administration records. They had found there was no system in place for rotating or checking medicine stocks. They showed us the checks they had put in place to reduce the risk of this occurring again. They had also arranged training on safe handling of medicine and were introducing staff competency checks. The manager had also completed checks on people's care records and found they had not been kept under review and were not up to date. In response they had developed new documentation and systems to ensure appropriate monitoring and recording of people' health and social care needs. We were unable to determine the effective of the new systems during the inspection as these had just been brought in and were being introduced on a phased basis.

The provider and manager had a clear vision for the service and were keen to make the required improvements to ensure people's safety and wellbeing. The regional manager recognised that the lack of accurate information on people's needs and dependency levels could compromise their safety. When we asked how they would manage the identified risks and prioritise their workload they managed to secure extra management support. This would allow them to assess people's needs and the support needed to meet their needs in a timely manner.

Staff were unclear whether they could ask for or access training. The manager had recognised that staff supervision had not been undertaken. They had completed group supervisions to ensure that staff were aware of their roles and responsibilities and areas that required immediate attention. The manager had also found staff training had not been kept up to date. They were working with their administration officer to set up systems to facilitate regular supervisions and to maintain an accurate overview of staff training. In view of their workload they had employed the support of an independent training organisation to establish and provide staff training. The manager also hoped to liaise and arrange training with specialist nurses for specific diseases people at the home were living with. We were unable to determine the effectiveness of the new systems during the inspection as the provider was still in the process of introducing them.

People and staff expressed anxiety about the home being in administration and what this could meant for them. One person asked us if the home was going 'down the pan? Staff we spoke with felt communication between staff and management was poor. One staff member said, "We care staff are not taken seriously even though we know the residents best". Another staff member told us, "They tell us what they want us to

do but do not seem to want to hear us". A staff member explained that historically staff views got overlooked but now felt there had been positive changes in the culture. The manager told us they wanted people and staff to be involved in making the required improvements. They aimed to start with involving people in developing their care plans and determining how they wanted their care provided. They were spending time getting to know people and their relatives. They acknowledged that staff supported people on a daily basis and would be well placed to advise on people's levels of needs and their routines. The manager intended to hold meetings with people and staff to keep them informed and involved in developments in the service.

One person told us, "[Manager's name] is very nice they came in to introduce themselves – quite pleasant". A staff member told us they thought that the new manager would do a 'fantastic' job. They had already put a lot of new things in place but the staff member felt that there was not enough resource to implement them all. The manager confirmed that there was a significant amount of improvement to be made. They felt the additional management support which had been agreed would help them to achieve what needed to be done to provide a good quality service.

People and their relatives felt that staff tried their best to meet people's needs within their available resource. One person praised staff efforts they said, "They (staff) never say no or get irritable but they are so busy. They get here eventually". A relative we spoke with was very pleased with the care staff provided and said, "I would recommend this home to anyone". Another relative told us their family member had been to a number of homes and this was the only one they wanted to come back to. Staff we spoke with told us they enjoyed coming to work and demonstrated that they were motivated to provide good quality care. One staff member told us in order to meet people's needs, "We all work together and help each other". Another staff member said, "I think we care for people the best we can with the tools that we have got". New and agency staff told us they felt well supported by the staff team and approached them for guidance if they were not sure about anything. One agency staff member said, "The other staff support me and tell me what they want me to do. I now feel part of the team".

We found that there had been two safeguarding incidents in February 2016 which we had not been informed of these. By law the provider must notify CQC of certain events, these are called statutory notifications. The manager told us they were aware that CQC should have been notified but did not know these had not been sent. They had however submitted subsequent notifications about different instances since they started.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of serious incidents that they are required to send us by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's ability to make decisions about their own care and treatment had not been appropriately assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicine were not managed safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always get the support they

Diagnostic and screening procedures

Treatment of disease, disorder or injury

needed because staff were not deployed effectively to meet people's needs.