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Braemar Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Braemar Lodge Care home provides accommodation and personal care for up to 13 older people. An unannounced inspection was carried out on 1 February 2016 and 2 February 2016. Some people living at Braemar Lodge had care needs associated with living with dementia. At the time of our inspection 13 people were living at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures 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.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
The service had a registered manager in post, however was no longer the manager of the service and was now working as part of the care team. A cancellation application from the registered manager has since been received in the Commission. A new manager had been promoted to this position and was in their first few days of managing the service when we carried out our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered Managers, 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.

Views about staffing levels were mixed and some people felt that there was not enough trained and experienced staff available to meet their needs. We also found that people or their families were not fully involved in planning and making decisions about their care. We found the service not to be responsive in identifying and meeting people's individual care needs.

The manager and Provider could not demonstrate how the service was being run in the best interests of

people living there.
Arrangements in place to keep the provider up to date with what was happening in the service were not effective. As a result there was a lack of positive leadership and managerial oversight. Systems in place to identify and monitor the safety and quality of the service were ineffective as they either did not recognise the shortfalls or when they did there was a lack of action to rectify them.

Staff did not have the skills and experience, and they were not deployed effectively to meet the needs of people. We found that staff did not always have enough time to spend with people to provide reassurance, interest and stimulation. There was a lack of knowledge around supporting and caring for people living with dementia including understanding how it affected people differently and how each individual should be cared for to promote their wellbeing as far as possible.
Medicines were securely locked away however the manager and Provider could not demonstrate that people received their medication as and when they needed it and/or as it had been prescribed. In addition the service did not monitor the room temperature of were the medication was stored which would help to ensure its quality and integrity.

The dining experience was varied as it did not meet all the people's individual nutritional needs. As a result the manager and Provider were unable to demonstrate that people had enough to eat and drink to support their overall health and wellbeing.

Although relatives told us that staff treated people with kindness and were caring, we found the way the service was provided was not consistently caring. Staff did not always demonstrate a caring attitude towards the people they supported and some failed to promote people's dignity or show respect to individuals. The majority of interactions by staff were routine and task orientated and we could not be assured that people who remained in their bedroom received appropriate care to meet their needs. This also meant they were socially isolated as opportunities provided for people to engage in social activities were limited.

Whilst we were concerned that some staff did not always recognise poor practice, suitable arrangements were in place to respond appropriately where an allegation of abuse had been made. There was a system in place to deal with people's comments and complaints however we found the service needed to be more open and transparent in their responses.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected against the risks associated with medicines because the manager and provider did not have appropriate arrangements in place to manage medicines safely.

Not all staff knew how to recognise and respond to abuse correctly, not all people felt safe and we found that the arrangements to keep people safe were not robust. Individual risks had not always been assessed and identified.

The recruitment process was robust which helped make sure staff were safe to work with vulnerable people. The deployment of staff was not appropriate to meet the needs of people who used the service.

Is the service effective?

Inadequate

The service was not effective.

The dining experience for people was variable and not always appropriate to meet people's individual nutritional needs.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service. Staff training provided did not always equip staff with the knowledge and skills to support people safely.

Improvements were required to ensure that staff recognised people's deteriorating healthcare needs and made sure that appropriate healthcare professionals were contacted at the earliest opportunity.

Is the service caring?

Requires Improvement

The service was not caring.

Not all care provided was person centred, caring and kind.

People and those acting on their behalf were not always involved

in the planning of their care.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People were not always engaged in meaningful activities and supported to

pursue pastimes that interested them, particularly for people living with dementia.

Not all people's care records were sufficiently detailed or accurate.

Staff were not consistently responsive to people's needs.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight of the service as a whole.

The quality assurance system was not effective because it had not identified the areas of concern and there were no plans in place to address them.

Braemar Lodge Residential 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 registered manager was 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 the 1 February 2016 and 2 February 2016 and was unannounced. The inspection was undertaken by two inspectors.

We reviewed other information that we hold about the service such as notifications, these are the events happening in the service that the registered manager is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

As part of the inspection we spoke with three people who used the service, three relatives and six members of care and support staff, the manager and provider. We spoke with one social work professional who was supporting people who lived in the service.

Some people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. We therefore used observations, speaking with staff, and relatives, reviewing care records and other information to help us assess how people's care needs were being met. We spent time observing care in the communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As part of this inspection we reviewed 13 people's care records. We looked at the recruitment and support records for five members of staff. We reviewed other records such as medicines management, complaints and compliments information, quality monitoring and audit information and maintenance records.

Inadequate

Is the service safe?

Our findings

Although people told us they received their medication as they should and at the times they needed them, the arrangements for the management of medicines were not consistently safe.

Prior to our inspection an unannounced visit by a Pharmacy Technician with the local Clinical Commissioning Group [CCG] was undertaken to the service on 26 January 2016. The visit by them highlighted that there were a number of areas relating to medicines management that required improvement.

At our inspection on 1 February 2016 and 2 February 2016 we found that not all areas highlighted for action by the CCG had been addressed. For example, on 26 January 2016 a bottle of liquid medication used for relieving severe pain was noted to be stored in the controlled drugs cupboard. The medication had been supplied without a label and had been opened for longer than the three month expiry date on the bottle according to the controlled drug book. The management team were advised by the CCG to return this medication to the supplying pharmacy as soon as possible. However, when we visited the service on 1 February 2016, we found that this medication had not been returned and remained in the controlled drug cupboard. Arrangements had not been made by the management team to act sooner and neither could the provider or manager provide a rationale for this.

We found a tablet on a person's chair in the lounge. We handed this to a senior member of staff at the time of the inspection. They were unable to provide us with any further information, such as, the identity of the person who's medication it was nor the name of the medication. This showed that the administration of medicines by staff for people was not as good as it should it be as staff administering medication had failed to ensure that the person had taken all of their prescribed medication. Additionally, we could not be assured that people received all of their prescribed medication. The medication administration records [MAR] for seven out of 13 people who used the service were viewed. The medication administration records for six people showed that there were unexplained omissions giving no indication of whether people had received their medicines or not, and if not, the reason why was not recorded. Where the code 'F' 'other – define' was recorded on the MAR form, an explanation for its use was not recorded on the reverse of the MAR form. Records showed that people did not always receive their medication in line with the prescriber's instructions. For example, records showed that two people using the service were prescribed a medication patch to relieve moderate to long-lasting pain and this was to be administered and changed every 72 hours or seven days respectively. However, we found over a four week period that there was one occasion whereby each person received their medication one day later then they should have. No rationale was recorded as to why this had happened and when discussed with the manager and a senior member of staff they could not provide a valid reason for this. In addition, we found that where two people were prescribed pain relief medication to be administered four times daily, the MAR form recorded that this was consistently being administered by staff as PRN 'as and when required' medication and was not in line with the prescriber's instructions. For example, for one person out of a possible 112 occasions between 21 December 2015 and 17 January 2016, the person only received their pain relief medication on six occasions.

On inspection of the service's controlled drug register we found that there were three numerical discrepancies. For example, the controlled drug register for one person recorded a balance of eight medicated patches but when we reviewed the actual medication held for safekeeping in the controlled drug cupboard we found that there were only seven medicated patches. When we cross referenced the information with the person's MAR form we found that the code 'E' 'refused and destroyed' had been recorded on 28 January 2016 but the controlled drug register had not been updated to reflect this.

Where people required parts of their body to be creamed so as to prevent their skin from becoming dry or for the prevention of skin breakdown, the administration of their topical cream had not been recorded to demonstrate that this had been given. We discussed this with the manager and a senior member of staff and they both confirmed that a 'Topical Medication Application' form was available but was not being used. During further discussions they confirmed that where people were prescribed a medicated patch, for example, for pain relief; a 'Transdermal Patch Application Record' to record the site of application on the body was not in use. This meant that we could not be assured that staff were alternating the medicated patch on the person's body.

Staff involved in the administration of medication had received medication training between 2013 and 2015. However, we found that the training had been delivered by the provider but they had not undertaken or achieved 'train the trainer' training relevant to medicines management. This is important so as to enable the person wishing to deliver training to be an effective trainer. Out of nine members of staff who administered medication to people using the service only two members of staff had had their competency to administer medication formally assessed and these were in 2014 and 2016 respectively. Additionally, three members of staff had completed a written controlled drugs knowledge test. No rational was provided by the provider or manager as to why competency assessments were not available for other members of staff, particularly given our concerns with the service's medicines management.

The manager and a senior member of staff confirmed that medication audits had been completed once weekly since 5 January 2016. An A4 sheet of paper detailed that a medication audit had been undertaken on 5 January 2016, 11 January 2016, 19 January 2016 and 25 January 2016. However, actual evidence of what had been audited was not recorded. We discussed this with the manager and the senior member of staff and they told us, "That's all we do to say it's been done." It is the Care Quality Commission's belief that had there been a more effective medication auditing procedure in place, this would have identified the issues we identified during our inspection.

Although intuitively staff knew the people they supported and risks were identified to people's health and wellbeing, for example, the risk of falls, poor mobility and the risk of developing pressure ulcers, where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service. Some staff were able to demonstrate an understanding and awareness of what they should do if they suspected that a person was at risk of abuse or harm. However, one member of staff was unable to tell us what safeguarding was and informed us, "Safeguarding is about making sure there are no hazards in the home." Records showed that staff had received in-house safeguarding training however it was evident that some staff did not have an understanding of safeguarding or how to protect vulnerable people from abuse.

We found that some information was contradictory. For example, where one person was deemed to be at risk of falls we found that the person's falls risk assessment recorded them as being at moderate risk, however the provider's own risk assessment in relation to 'slips and falls' recorded them as being at low risk. Staff we spoke with were unclear as to which assessment was accurate. The daily care records for the same person evidenced over a period of two weeks that the person's nutritional and hydration needs had

declined. No risk assessment was completed detailing the actions to be taken to mitigate any risks to the person. The same person also had pressure ulcers to their sacrum and heels. Whilst a pressure ulcer risk assessment had been completed which determined the level of risk, no risk assessment was completed detailing the actions to be taken to mitigate any risks and to aid pressure ulcers from developing or deteriorating further. No risk assessments were completed for three people newly admitted to the service. This was despite there being associated risks, particularly in relation to their mobility. Information available confirmed that each person had a history of falls, had been admitted to hospital following a fall and sustained a serious injury.

In addition, where people were at risk of developing pressure ulcers, appropriate arrangements were not in place to ensure that people were having their body repositioned at regular intervals in line with their care needs or that pressure relieving equipment was fixed at the correct setting. The care records for one person showed that they should have their body repositioned every two hours so as to relieve pressure on key areas of their body. However, repositioning charts indicated every three hours and also showed that this was not always happening as frequently as they should have been happening.

During the inspection we observed that two people using the service had bedrails fitted to their bed so as to reduce the risk of falls. Bedrails are classed as 'medical devices' and should be used in line with the Healthcare Products Regulatory Agency [MHRA] to ensure these are acceptably safe and used in line with MHRA guidance. We found that no bedrail risk assessments had been considered to ensure that these were appropriately fitted and safe for the person using them. Additionally we observed during our night inspection to the service that an armchair had been placed up against the bed and was being used to prevent them from falling out of bed. Records for them detailed that staff were concerned that they may fall or roll out of bed and there were occasions whereby staff had found the person either having fallen out of bed onto the floor or partially hanging out of bed. It was of concern that no thought had been made to consider the use of bedrails so as to ensure the person's safety.

All of the above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At our inspection we were concerned about the number of staff available to meet people's needs. Our observations over the two day inspection showed that although there were three members of staff on duty during the period of 09.00 and 11.00 people were left in the communal lounge nearest to the kitchen without a member of staff present. Where people required close monitoring due to high risk of falls or becoming anxious and distressed towards other people, there was not always a member of staff to monitor or support people. For example, during the two days of our inspection we observed one person repeatedly going into other people's rooms and being anxious and distressed towards other people using the service. There were not enough staff available to ensure this person's needs were met in order to avoid anxiety.
Staff's comments about staffing levels at the service were varied. Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others informed us that staffing levels were inadequate to meet people's needs and that this could be stressful especially when the home was at full capacity. Staff told us that the impact of this was that people could not always go to bed at the time of their choosing and/or preference.

The manager and provider were unable to confirm how staffing levels at the service were calculated so as to determine the number of staff necessary to ensure that people's needs were met. There was a lack of a systematic approach to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances. For example, on 1 February 2016 at the time of our arrival we observed that one small communal lounge had three people

present. We observed that between 09.00 and 11.00 no staff were present in the lounge area so these people were left without support.

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

The service ensured that it employed suitable staff because a clear recruitment process was followed. This made sure that that staff were suitable to work with people in a care setting. Relevant checks had been carried out including obtaining at least two references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

Inadequate

Is the service effective?

Our findings

At our inspection we noted that most staff had received training to carry out they role. Although staff training records showed and staff told us that they had received suitable training to meet the needs of the people they supported, this was not embedded in their everyday practice and their competency was not being assessed. Staff told us that the majority of the training provided was through e-learning or watching a video and staff did feel that this was an appropriate method to aid their knowledge, understanding in their role or test their competency.

On the first day of our inspection we observed two members of staff assisting a person to move in a way that was unsafe and put them at risk of harm. The person grimaced, started to shake, looked to be uncomfortable whilst this was being carried out. When the inspector spoke to the two members of staff about this unsafe practice, one member of staff acknowledged that a sliding sheet should have been used. Although records showed that each member of staff had received manual handling training, this showed that staff did not know how to apply their training and provide safe and effective care to the people they supported.

Several people were living with dementia, some in the early stages of the condition whilst others were living with more advanced dementia. Although staff told us they had received training relating to dementia, we found examples of poor staff practice which indicated a lack of understanding and application of the learning from training provided. Some staff did not demonstrate an understanding of how to support people living with dementia and how this affected people in their daily lives; for example, some staff did not communicate effectively with individual people or provide positive interactions. For example, one person tried to initiate a conversation with a member of staff and held out their hand. The member of staff was observed to be dismissive. Although the member of staff was seen to look at the person, they walked out of the room without responding to the person. The training did not equip staff to communicate effectively with people living with dementia or had communication difficulties.

Staff informed us that when they commenced employment they went through an induction programme, had on-going training, one to one support, team meetings and daily handovers. We found majority of the staff had not received regular supervision in the last 12 months. Staff confirmed that there was not enough time in the day for formal supervision to be undertaken.

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

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

People can only be deprived of their liberty 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 found that staff received relevant training on MCA and DoLS. This meant that staff were not able to demonstrate how this affected people where a DOLS application would have been made or arrangements in place to ensure their safety in the interim period. We found the service had not made any DOLS applications to the Local Authority for them to be considered and authorised. This had also been highlighted to the provider by the Local Authority prior to our visit.
Information relating to people's ability to make decisions, or the decisions that they may need help with was not clearly recorded.

We found mental capacity assessments on day to day decision making to be generalised on the basis of people's cognitive impairment diagnosis for example people had been deemed not to have capacity to make any day to day decisions due to them having dementia. Each individual's needs should have been assessed as capacity levels can vary depending on the decision being made for example what clothes they liked to wear, where they would like to eat their meal, choice of food, the time they got up in the morning and the time they retired to bed and how they liked to spend the rest of their day.

We spoke to the manager who could not demonstrate if the service had consulted people or their relatives as to what food and drink they would like to have or how it was prepared. The manager informed they were in the process of making visual aids menus as the previous manager had removed the old ones. During the tea round we observed that people were not being given an option of tea or coffee rather most people were served tea. We also observed staff not asking people what choices of biscuits they wanted to have, biscuits were served by hand by staff and people were not offered a plate or serviette to place their biscuits. On speaking to the cook they informed they spoke to each person in the morning to ascertain what each person wished to have for lunch. Cook's record book showed that people had been offered a choice of main meal and dessert.

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

Requires Improvement

Is the service caring?

Our findings

Although some people and their relatives told us staff were caring and kind, our observations showed this was not always consistent. We saw where people were not able to verbalise, staff interactions were limited in there frequency and not personalised. We observed that on occasions staff spent time talking with each other rather than interacting with people.

Staff did not support people in a person centred way, their responses and interactions with people were often task led and routine based. For example, people at times had to wait long periods before being supported and people were not being engaged and staff did not always spend time speaking with people or acknowledging them as individuals.

Not all people who used the service received interaction with staff other than being given a drink. There were three people who spent time either asleep or looking ahead without engaging in the surroundings. Throughout most the first day of our inspection we observed one person try to engage with staff but repeatedly staff walked past them and did not make any eye contact or attempt to respond to them despite the person holding they hand out to staff that were walking past them.

Our observations showed that people's dignity was not always respected. For example, on our first day of inspection we observed that three people were left from the 09.30 to 17.30 without being toileted nor offered to toileted despite care plans stating these three people required assistance and prompting with toileting. We did not see the people being taken to the toilet during our observations of the first day. Throughout our inspection we observed one person in particular repeatedly try to engage with staff but were often ignored as staff walked right past them. We saw one person being supported by two staff members to transfer to a chair. The staff members continued with their conversation and did not speak with the person whilst they were supporting them and until the task was completed.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found advocacy information displayed within the service. An advocate provides support and advice to people and is there to represent people's interests. However, when we spoke to people and relatives about who they would turn to should they need external support they had very little knowledge of who they would speak to.

Inadequate

Is the service responsive?

Our findings

People did not always receive care in a person centred way because the deployment of staff meant staff's approach was mainly task and routine focused. This meant that interactions between staff and people using the service were primarily focused around the provision of drinks, meals and providing personal care.

We found that people's care was not always planned and assessed to ensure people's safety and welfare. Others were not fully reflective or accurate of people's care needs. Some people's care plans did not contain sufficient relevant information on how people's dementia affected their day-to-day living and how they were to be supported. They did not include detail about people's strengths, abilities and aspirations.

People admitted from hospital did not always have care plans in place for staff to understand and meet their needs. For example, at the time of our inspection there were three people in the service who had no care plans in place, of which two people had been admitted to the service three days prior to our inspection. For example, the only information in place for one person was the 'Assessment of Needs' document provided by the local NHS Hospital. This document detailed that they had a serious leg fracture, required encouragement to eat and drink, required hoisting and required catheter care. No care plan was in place detailing how their care and support needs were to be met by staff. In addition there was no information or guidance for staff on how the care and support should be provided or the associated risks and the steps to be taken to mitigate these. This was not an isolated case, for example, for another person, the only information in place for them was the 'Assessment of Needs' document provided by the Local NHS Hospital. This document detailed that they had a hip fracture, required stoma care, suffered with anxiety and depression and was diagnosed with the medical condition of diverticulitis, which can cause constant and severe pain in the abdomen. No care plans were in place detailing how their care and support needs were to be met. In addition there was no information or guidance for staff on how the care and support should be provided or the associated risks and the steps to be taken to mitigate these. We discussed this with the provider and they confirmed that it was their expectation that the care plans for both people should have been completed. The manager was asked by the provider to provide a rationale as to why no care plan documentation had been completed and implemented. The manager stated, "I have been busy."

Staff told us that there were some people who could become anxious or distressed. The care plan for one person was viewed and this showed that no care plan relating to the reasons for the person becoming anxious and the steps staff should take to reassure them was in place. In addition, assessments of the behaviours observed and the events that preceded and followed the behaviour were not consistently robust, completed or easily accessible so as to provide a descriptive account of events including staff interventions. We spoke with two members of staff. One member of staff was able to tell us in detail how the person demonstrated their anxious and distressed behaviours and how this impacted on staff and others living at the service. They were able to demonstrate a good knowledge and understanding of the person's needs that was accurately recorded within behavioural charts and daily care records. However they confirmed that they had not read the person's care plan and were unaware if a risk assessment was in place. This was in contrast to our discussion with another member of staff. The member of staff provided information that was not reflective of the person's needs, for example, they told us that when the person

became anxious and distressed this was solely directed towards staff and not others living at the service. Behavioural charts and daily care records for the period 13 December 2015 to 31 January 2016 inclusive showed that when they became anxious or distressed this could be directed to both staff and others living at the service. The member of staff confirmed that they had read the person's care plan and this included guidance for staff on how to deal with the person's anxious or distressed behaviours and associated risk assessments. This information was not recorded within their care file and did not concur with our findings.

People had not always received effective support to care for their healthcare needs from the GP, District Nurse and end of life care team who visited people requiring support on a regular basis. However, for those people living with dementia, the service had not sought support from the local dementia service or CPN (Community Psychiatric Nurse). Records highlighted that for some people additional support was required to manage their emotional wellbeing and anxieties. However no external support had been sought and best practice guidelines were not readily available or being followed.

Our observations throughout the inspection showed that there were few opportunities provided for people to join in with social activities. There was a lack of meaningful engagement and people were not supported to pursue their interests or hobbies. There were activities in the afternoon on both days, but the level of activities provided was poor. For example, we observed the activities co-ordinator playing ball with three people in the small communal lounge for a period of 10 minutes. On the second day of inspection we saw the activities co-ordinator give a magazine to three people but did not spend any meaningful time with them discussing the images and opening up a discussion. We also observed them play a game of cards with one person and then played their guitar for a short while.

All of the above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service well-led?

Our findings

Quality assurance systems and processes which assessed, monitored or improved the quality of the service were not effective or established. The provider and manager could not evidence any effective systems or processes which assessed, monitored or mitigated the risks relating to the health, safety and welfare of people using the service. The provider and manager was unable to demonstrate how they continually analysed, evaluated and sought to improve their governance and auditing practices in line with their own quality assurance policy. The provider's quality assurance policy and procedure had not been updated as it still made reference to the 'Essential Standards of Quality and Safety' and not the 'Fundamental Standards' that were introduced on 1 October 2014. It detailed that the provider's audits included observations of staff practice, audits of three people's care plans at three monthly intervals, an audit of all untoward incidents and an audit of safeguarding concerns so as to ensure these were monitored and investigated. In addition to this the provider's quality assurance policy and procedure detailed that an audit of quality records including the personalised records for people using the service were maintained, monitored and reviewed. We found no evidence to show that these had been completed and both the provider and senior member of staff confirmed that this was accurate.

Although some systems were in place, they were ineffectual and had not highlighted the areas of concern we had identified at this inspection. There was no evidence to show that the providers quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety were compromised, to drive improvement or to respond appropriately. In addition systems in place did not mitigate risks relating to the health, safety and welfare of people using the service. For example, quality assurance checks were not in place to monitor and make sure that an analysis of accidents and incidents or falls were completed at regular intervals to identify and analyse the data or to establish what caused them. However, the accident records for four people were viewed and these showed over a period of several months that they had experienced several falls and in some instances also sustained an injury. No analysis of the information was in place to monitor potential trends, for example, the frequency of falls, the specific circumstances surrounding the fall and the actions to be taken, such as, referral to the local falls team or a discussion with the person's GP to review their medication.

Records relating to staff employed and people using the service were not properly maintained. This related to staff training, induction and supervision. Where the provider had completed an internal audit and areas for improvement had been highlighted, no evidence was available to show where these had been completed or required to be followed-up. For example, the audits for December 2015 and January 2016 highlighted that care plans for people newly admitted to the service required completion and risk assessments required review. Our evidence at this inspection showed that these remained outstanding and had not been completed. The provider did not have an effective system in place to review staffing levels to ensure that the deployment of staff was suitable to meet people's needs. It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner. The provider was unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act 2008. This showed that there was a lack of provider and managerial awareness and oversight

of the service as a whole as to where improvements were required.
The senior member of staff confirmed that the views of people who used the service and those acting on their behalf had been sought in 2015. Comments relating to the care and support provided for people living at the service were noted to be complimentary and positive. Comments included, "I have no concerns about the care the staff give my relative" and, "No changes needed. Everyone is very kind and patient. They [staff] always seem to be very well informed." Where negative comments were recorded these related to more activities for people living at the service. Comments included, "Suggest some 1-1 with residents" and, "Some activities to get service users engaged."

All of the above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Both the provider and the manager and staff lacked knowledge of the requirement to notify us of incidents and both expected and unexpected deaths. No statutory notifications had been sent to us since February 2015. We found that between February 2015 and 2 February 2016 there had been three deaths that the provider and manager were required to notify the Care Quality Commission of and a number of serious injuries had occurred during this time that had also not been notified appropriately.

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

At the time of the inspection the service did not have a registered manager in place as the previous registered manager had changed their role within the service to that of senior carer. The provider confirmed that one of the senior carer's had been promoted to the role of manager and this had commenced two weeks prior to our inspection. The manager confirmed at the time of our inspection that an application to be formally registered with the Care Quality Commission had not been made. There was lack of clear leadership in regards to who was managing and running the service. Staff told us that they found the change of managerial roles confusing as they were not always sure who to go to for advice and support as the incoming manager was heavily reliant on the previous manager for advice and support.
The provider and manager were unable to demonstrate an understanding of the fundamental standards introduced from 1 October 2014 or our new inspection methodology. The manager confirmed that they had not had sight of the fundamental standards and were not able to tell us about the five domains [Safe, Effective, Caring, Responsive and Well-Led] and how this related to how the service should run.

Since our inspection we have written to the provider highlighting several concerns we found and have requested an action plan to be drafted, on how the service will improve care and treatment for people using the service.