Four Seasons 2000 Limited

Osborne Court 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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 27 July 2017. This was the first inspection since the service was registered under a new legal entity, Four Seasons 2000 Limited. The service was previously registered under the legal entity of Laudcare Limited.

The inspection was unannounced. Osborne Court provides nursing and personal care for up to 55 people. At the time of our inspection there were 37 people living in the home.

There was no registered manager in place at the time of our 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. One of the provider's area resident experience care specialist's was taking overall management responsibility for the home. They are referred to in this report as the interim manager.

Most people told us they felt safe in the home. However, we found medicines were not always safely managed and risk assessments and risk management plans were not always fully completed. Staff understood their responsibilities with regard to keeping people safe from avoidable harm and abuse.

People's healthcare needs were not always met. Staff were not always provided with sufficient information about actions to take when people's needs changed. Staff were not always provided with sufficient support and supervision.

Staff demonstrated a kind and caring approach and they treated people with dignity and respect. Staff knew people well and were able to tell us about people's likes, dislikes and preferred routines which were reflected in their care records.

The programme of engagement and activity varied within the home. People living in one area of the home were engaged and occupied. In another area of the home people were not provided with sufficient activity during the day.

There was no registered manager in post. Most people were not aware of the management arrangements in the home. Staff expressed concerns with regard to the lack of consistent leadership and management.

We found four breaches of the regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report. We also made recommendations for further training to be provided for Deprivation of Liberty Safeguards (DoLS) and diabetes management.

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 always safe.

Medicines were not always safely managed and risk management did not always identify and mitigate risks to people's safety.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff performance was not always monitored on a regular basis.

The home was meeting the requirements of the Deprivations of Liberty Safeguards (DoLS) authorisations. We have recommended further training to make sure staff are aware of their responsibilities for meeting DoLS conditions.

Staff did not always ensure people's health care needs were met. People had access to health care professionals.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and respectful and we saw people being treated with compassion and dignity.

Staff knew what peoples' individual needs, wishes preferences and choices were.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always personalised and did not always

reflect people's changing and current needs.

Activity provision varied within the home and people were not always provided with sufficient activity and engagement some areas of the home.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well- led.

There was no registered manager in post. Interim arrangements were in place.

Systems were in place for monitoring quality and safety. However, the audits had not identified the shortfalls we found with regard to medicines management and personalised care planning.

The interim manager was aware of their responsibilities with regard to notifications and information they were required to send to the Commission.

Osborne Court 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.

We undertook a comprehensive inspection of Osborne Court on 27 July 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of the type of service inspected.

Before carrying out the inspection we reviewed the information we held about the care home. We looked at notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with 13 people who lived at the home and one visitor. We observed the way staff interacted and engaged with people.

We spoke with the interim manager, the area manager, a resident experience care specialist and eight staff that included a registered nurse, care staff, catering, housekeeping and laundry staff. We observed how equipment, such as pressure relieving equipment and hoists, were being used in the home.

We looked at eight people's care records. We looked at medicine records, staff recruitment files, staff training and supervision records, audits and action plans, and other records relating to the monitoring and management of the care home. Following the inspection, a resident experience care specialist sent us further information that we had requested.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. We saw medicines had been left in one person's room for the person to take after their lunch. This was not in accordance with the provider's policy that stated, 'Observe the person to ensure that the prescribed medication is taken in the way in which it has been prescribed.' We also saw a container of fluid thickening agent, that should be securely stored, was left on a person's chest of drawers.

One person was prescribed insulin to control their diabetes. The care plan for the person stated they should be given insulin if their blood sugar level was above a stated level. The insulin had not been given on the morning of our visit. The registered nurse told us they had been informed by the night staff the person's blood sugar was below the stated level. The night staff had not recorded the person's blood sugar level. The registered nurse told us this must be an oversight. However, there was a risk that the verbal handover may not have accurately communicated the person's blood sugar levels and they may not have received the injection of insulin when they needed it. The person's blood sugar levels were recorded on other days.

We looked at the records for two people who received their medicines covertly. This meant they did not know the medicines were being given. The provider had a protocol in place. We saw this was followed for one person. For the other person the member of staff told us they had started administering the medicines covertly and this had been agreed with the GP. However, the protocol had not been followed and the records did not follow the provider's guidance. A multi-disciplinary meeting had not been held and a care plan explaining the decision and actions taken had not been completed. The member of staff told us the actions had been planned and would be completed the day after our visit.

Some people were prescribed creams or ointments. The prescribing instructions were recorded on a topical medicine administration record (MAR), and staff signed to confirm they had been applied. However these were not always fully completed. For example, one person had a cream prescribed to be applied three times each day. At the time of our visit staff had signed to confirm they had applied the cream on three days during July. Another person had cream prescribed for application once each day. The records had not been completed for 11 days in July. We also saw a cream in one person's room that had not been prescribed for that person. The cream was not labelled with a person's name or with prescribing instructions.

Risk assessments and risk management plans were in place for areas such as falls, moving and handling, skin integrity and nutrition. Where risks had been identified, the care plans generally contained clear guidance for staff on how to reduce the risks. Where moving and handling equipment was needed to move a person safely, most plans provided detail of the type of hoist and the size of sling that was required.

However, some risk assessments and risk management plans were incomplete and had not been regularly reviewed and updated. For example, in one person's care plan it was recorded on 7 May 2017 they needed, 'Stand aid [type of hoist] with appropriate sling.' On 8 June 2017 it was noted that an external professional had observed staff using a sling that was too big for the person and they should be reassessed 'as a matter of urgency and ensure the correct sling is used'. The records after this date did not provide evidence that

action had been taken and that the correct sling had been provided. We brought this to the attention of the registered nurse in charge. They were not aware if actions had been taken to address this shortfall.

In another person's care plan staff had recorded their concerns about a person who asked to be taken outside to smoke in the early hours of the morning. The staff were concerned about whether the person was safe to be left outside alone. The concerns had been recorded on 12 July 2017. The registered nurse in charge told us the person had the capacity to make this decision. However, a risk assessment and plan had not been completed or agreed with the person. For example, there was no plan for how the person could summon help if needed, or how frequently the person may need checking while they were outside the building.

The above were breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines received into the home were checked and the amounts confirmed on the medicine administration record sheets (MARs). Medicines were suitably stored in locked cabinets and cupboards in designated rooms. Arrangements were in place for medicines that required cool storage or additional security. Records were maintained for medicines no longer required.

We observed medicines being given to people and this was completed in a kind, caring and unrushed manner by the senior care staff and registered nurses. For example we heard people being asked, "Here you are. Would you like them one by one?" Some people were prescribed medicines to be taken when needed, for example, for pain relief. Protocols were in place to describe the types of pain the medicines were prescribed for. We heard people being reminded and asked if they had any pain and if they needed their medicines. Staff recorded the effectiveness of the medicines. For example, one person's records stated they had been given a medicine because they had a headache. The records them confirmed the medicine had been effective and the person's headache had been relieved. We saw that staff signed the MARs after they had made sure people had taken their medicines.

Some people had been assessed as being at high risk of falls. The care plans provided guidance such as, 'encourage to use walking frame' and, 'needs two staff to assist with all transfers'. We looked at care plans which stated that staff should complete safety checks for people at specific times such as, 'Thirty minute checks'. These were fully completed in the records we looked at.

People who were able to fully express their views told us they felt safe in the home. Comments included, "I am safe here because all of the staff are so helpful" and "I am safe and looked after." One person told us they felt safe even though other people went into their room sometimes. They told us that people left when they were asked to.

Some people were unable to use call bells to call for assistance. However, we saw people who were able to use their call bells, but they were not always within reach. For example, one person told us they had fallen on occasions and had, "Got myself into the doorway and called out for somebody."

All of the staff we spoke with told us they had received training and understood their responsibilities for protecting people from avoidable harm and abuse. Staff knew how to report concerns and told us they would not hesitate to raise issues of concern with the managers, the Care Quality Commission or the local safeguarding team. Staff were also familiar with the term, 'whistleblowing'. They told us, "We're encouraged to speak up if we see any bad care" and, I wouldn't put up with it [poor care], I'd report it straight away".

The staff gave mixed comments on whether there were enough staff on duty to meet people's needs. Comments included, "I think its ok yes, although we really need five staff downstairs", "There is not enough staff. We all try to give good care, but we could do better. We don't have time to sit and talk to residents and it would be nice to be able to offer people more baths", "If we had more staff we could take people to the toilet more often, and have time to talk to people. It feels like a conveyor belt sometimes" and, "I think mostly there is enough staff". We spoke about staffing with the area manager and the interim manager. The provider used a dependency tool to determine the staffing requirements needed for the numbers and dependencies of people living in the home. The staffing rotas were maintained at the levels recommended. However, the home was reliant on the use of agency nursing staff to supplement where there were staffing vacancies. There was only one full time registered nurse employed in the home. When they were not on duty, agency staff were in charge of the nursing care provision for people receiving nursing care in the home.

Other staff told us, "I think people's physical needs are met, but not their social needs" and, "I think people are lonely. If I get five minutes I sit and talk to people, but it's rarely more than that".

Accidents and incidents were reported and recorded on an electronic system. There was a full description of the accidents or incidents, immediate actions taken and steps required to minimise the risk of recurrence. This included a 'Lessons learned' section.

Safe recruitment processes were completed. Staff completed an application form prior to employment and provided information about their employment history. Previous employment references had been obtained by the home together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Where required, the service had ensured that staff were appropriately registered with the correct bodies, for example the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella checks, electrical safety, lift maintenance and hoist checks had been completed.

Systems were in place to ensure that fire safety was adhered to. A fire risk assessment had been completed and records showed that regular safety checks were undertaken.

Requires Improvement

Is the service effective?

Our findings

We spoke with staff who gave mixed views about the level of support and supervision they received to enable them to carry out their roles. Staff commented that because there was no registered manager in post, there had been a lack of consistency in the support and supervision they received. Comments included, "I had one (supervision) when I first started but I haven't had one since" "I had one (supervision) recently but that's the first this year" and, "I can't remember the last time I had a supervision". The area manager told us staff should receive bi monthly supervisions, one of which would include an annual appraisal. We checked the records for 35 staff. Thirteen staff had received the number of supervisions in accordance with the provider's policy.

This was a breach of Regulation18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people spoke positively about the staff who supported them. They told us they were well cared for and that staff met their needs. Comments included, "They are nice girls, well trained, all of them, they will calm you down if you get upset" and, "Staff are very capable, they know what to do and what I need". However, one person told us, "My needs are not being met, they cannot give me what I want here". This person told us they had spoken with their social worker and they were looking for another care home.

The interim manager and area manager told us about the range of training provided for staff. This included training they described as mandatory that included health and safety, first aid, moving and handling, food safety, mental capacity and safeguarding. Staff were also provided with further training, designed to help them meet the individual needs of the people they were providing personal and nursing care for. We spoke with staff who told us they had recently received training for pressure ulcer awareness and dementia care framework training. Staff spoke positively about the training they had received and how the dementia care framework training had helped them understand the needs of people who were living with dementia.

We spoke with staff who told us they had not received training about how to provide support to people with distressed or challenging behaviour. We read in care plans that some people were described as 'anxious' or 'may shout loudly' and 'may experience hallucinations or delusions'. Staff were unable to tell us how they would provide sufficient care and support to people on these occasions. The area manager showed us the records and told us a training plan was in place to address the shortfalls in training staff had received.

Prior to our visit, concerns had been raised about staff responses to people when their condition changed. The registered nurse on duty told us they had recently received emergency escalation training to support them to deliver more effective care at such times. However, we looked at the care plan for one person who received insulin injections to control their diabetes. Other than the prescribing instructions for the circumstances in which to administer the insulin, there was no specific further guidance for staff about the signs and symptoms the person may display if they were unwell and if they experienced low or high blood sugar levels. The person's blood sugar levels did vary significantly from day to day. This meant the person may not receive the care needed as their condition changed.

We recommend that up to date nationally recognised diabetes training is provided to enable staff to recognise, respond and provide effective care to people with diabetes.

Staff completed an induction programme when they started in post. The programme incorporated the Care Certificate, a national training process introduced in April 2015, designed to ensure staff were suitably trained to provide a high standard of care and support. The interim manager told us the induction programme started with staff undertaking online training, before they started working shifts where they were supported by a more experienced member of staff.

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.

In the records we looked at, consent to care had been obtained from people. Where people were unable to provide consent we saw best interest decisions were made. These were fully recorded and provided information about how decisions had been made and who had been involved.

We spoke with staff who told us how they supported people to make choices about day to day decisions. We heard staff asking people, "Where would you like to sit" "Is this ok for you" and, "Can I help you with that". One person was sitting alone in their wheelchair in a dining room after they had breakfast. Music was playing and they were singing along to the music that was playing. We watched as staff asked the person if they would like to move to another more comfortable area to sit and have coffee. The person told the staff to, "Go away, clear off, I'm staying here" and "No" when they were offered a hot drink. The person's choice to stay where they were was respected. The member of staff made a decision to quietly place a cup of tea in front of the person and suggest they try it. They told us the person would enjoy the drink. We saw the person did drink the tea and looked like they enjoyed it.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA.

The managers had not fully met their responsibilities with regards to DoLS. There were 24 applications for people that were awaiting assessment by the local authority. Three people had current authorised DoLS in place. We checked the authorisations and the conditions stipulated for two people. The care plan listed the conditions. When we checked through the care records we saw evidence that some actions had been taken in accordance with the conditions. For example, for one person one of the conditions was they should be referred to the dementia wellbeing service. There was no record of this referral being made. However, for another person their condition stated they should be supported to get out of bed at least every other day. This was taking place. We spoke with senior staff who did not know why the actions above were in the care plan. They were not aware they were part of DoLS conditions. One member of staff told us they thought the person was getting out of bed in response to a request from relatives.

We recommend further training is undertaken to make sure all staff are aware of their responsibilities with regard to people with DoLS authorisations in place.

The catering team were informed of people's specific dietary needs. These were recorded on a white board

in the main kitchen. We spoke with catering staff about how they became familiar with people's likes, dislikes, choices and preferences. They told us they were sometimes asked to provide food that was not in accordance with what they had been informed was needed, for example, for people who were on textured diets. The provider's improvement plan for May 2017 stated that people's diet notification forms needed updating and forwarding to the catering team. This was to be maintained in addition to the white board information. These had not been updated when we visited. We brought this to the attention of the interim manager. There was a risk that people may be given incorrectly textured diets that were not in accordance with their assessed need. This meant people may be at risk of choking.

We spoke with people who gave mixed feedback about the quality and choice of food available. Comments included, "Food is good. It is cooked lovely and it is what I want. They only give you what is good for you here, and they make sure you can cut it up" "Food is half and half, sometimes good, sometimes not, it is definitely not like home cooking but you can have an omelette if you don't fancy what's on offer" and, Food is bland, not a lot of variety, but we get enough to eat".

We observed meals served to people in their rooms and in the dining areas. There was a calm atmosphere and quiet background music was playing. People were asked where they would like to sit. People in wheelchairs were asked if they would like to move to dining chairs. Everyone we saw who was asked declined the offer and chose to sit in their wheelchairs. People were asked if they would like clothes protectors. Staff offered people choices of drinks and provided support and encouragement to them. Pictorial menus were displayed in the dining room on the first floor. Where people needed assistance, this was done sensitively and people were not rushed. One member of staff walked beside one person who was walking constantly up and down the corridor. They did not sit down to eat their meal. The member of staff offered mouthfuls of food to the person and supported them to eat all their main meal and dessert.

We saw people being supported with meals in their bedrooms. We heard people being asked by staff, "Have you had enough" and, "Are you full"? One relative told us that some staff encouraged and supported the person to eat, and others didn't provide the encouragement the person needed.

People's weights were recorded and significant weight loss or gains were noted. There was also a nationally recognised tool used to calculate people's risk of malnutrition or obesity. When a person had been identified as having a significant weight loss or gain, additional actions were recorded if required. For example, one person had lost weight. The GP advised for the person's weight to be monitored for a further month and recorded each week. Their food and fluid intake was to be recorded. It was noted the GP planned to prescribe food supplements if there was further weight loss.

People were referred and had access to external healthcare professionals. District Nurses provided additional support for people living in the home who received personal care. The records showed people had received support from visiting speech and language therapist (SALT) assessors, wheelchair services and from social workers.

Good

Is the service caring?

Our findings

Most people we spoke with told us that staff were kind, caring and treated them respectfully. Feedback included, "Staff are very kind and lovely, they make you feel special. They repeat things if you do not understand and they will listen to you" "Staff are very kind. They put up with me and treat me respectfully. They are lovely young staff" "Carers are very friendly. They are all nice. I feel at ease with them when they have to help me with personal things. We just chat while they are doing it [providing personal care], nothing serious, just ladies stuff".

One person described how they felt they had not been treated with respect on one occasion. They told us staff had not provided care when it was needed and the person said, "They [the staff] kept coming and saying they would be here in two minutes, but they weren't. It was so undignified".

We watched interactions with staff, and people looked relaxed and comfortable in their presence. Staff were attentive and sensitive to people's individual needs. The care staff we spoke with told us how they got to know people well. A member of staff took breakfast on a tray into a person's bedroom. The person asked, "Just one piece of toast"? The member of staff replied "Of course. I always remember". The person replied, "Yes you do. It really puts me off if too much is put on my plate and I really enjoy just one piece of toast". The member of staff said kindly, "Yes I would be the same, it's no good loading up a plate if you're not that hungry". This showed the member of staff had a real understanding of the person's needs and what was important to them.

Staff listened to people and provided responses that were encouraging and supportive. For example, one person had put on an extra shirt and commented they specifically liked the colour of one of the shirts. A member of staff commented sensitively and suggested the person may be too warm and to just keep one shirt on. With the person's agreement they both went to the person's bedroom, closed the door, and the person was supported to remove their additional clothing and keep their preferred shirt on. This meant the person's dignity was maintained and they were supported to wear clothing that was appropriate for their needs.

Staff were able to describe how they made sure people's privacy and dignity were maintained. For example, one member of staff told us, "It's important to knock on peoples' doors, close the curtains and make sure no one comes in when we're giving personal care". Another member of staff who had recently started working in the home said, "I didn't really know what to expect, but staff are really kind, caring and respectful". We saw people's clothing was protected, if needed, when they were being supported with food and drink. People were quietly asked or shown the clothes protectors before they were placed over the person's clothes. This gave people the opportunity to participate and make choices.

Staff working in the area of the home that provided care for people living with dementia told us how the dementia care framework training was helping them to provide a more caring service for people. They told us about the resident charter and the family charter. The resident charter contained a statement, 'The people who look after me have taken the time to find out who I really am'. Staff told us they had made

commitments to provide better care, to keep people informed and involved and that people could trust staff to provide the right care.

People and their relatives were supported to express end of life wishes and preferences and these were recorded in the care plans.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always responsive and personalised to peoples' individual needs. They did not always provide enough guidance for staff on how to meet people's needs. For example, one person had mental health needs and sometimes experienced delusions. The guidance for staff was, 'Reassurance to be given when experiencing an episode of delusions' and. 'Distraction techniques to be used rather than enter into discussions'. There was no detail of what distraction techniques staff should use. We asked staff how they provided reassurance and how they distracted to the person. They were unable to fully explain how they supported the person. Comments from staff included, "I try to calm them down" and, "We go in pairs" and "I wouldn't know how to deal with a delusion".

One person also had a diagnosis of chronic obstructive airways disease. There was no care plan to provide guidance to staff about the care and treatment the person may need. The person had spent time in hospital because of this illness. This meant there was a risk that staff would not know the signs and symptoms the person may display if their condition deteriorated again.

In another person's care plan it had been recorded in their cognition plan, 'Difficult to communicate and no cognition". There was no guidance for staff on how to meet this person's communication needs.

One person had a pressure ulcer. Their care plan did not have photographs in place which meant it was difficult to assess for signs of improvement or deterioration. On 20 May 2017 the records stated the person had a grade 2 pressure ulcer. An entry in the records dated 26 May 2017 stated the pressure ulcer was 'Getting better, seems grade 1 at present time". There were no further entries in the care records relating to the pressure ulcer.

It was not clear how responsive staff were to people's needs, because in some of the plans we saw that staff had identified issues, but these had not always been followed up. For example, we saw that in one plan staff had documented a concern about a person self-harming. The member of staff had recorded, 'I will hand this over to be followed up'. This had been written on 9 July 2017 and there were no further entries within the person's records. This meant the person may not have received the care, support and treatment responsive to their specific needs. We brought our concerns to the attention of the registered nurse in charge. They were not aware this had been reported.

The above was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We read other plans that contained much more detail and provided clear guidance for staff. For example, in one person's plan it had been recorded they could become anxious at times. The guidance for staff was to, 'Reassure that everything is ok, or leave alone and allow to calm down in own time. Enjoys talking to staff and going for walks'.

Two people we spoke with told us they had been assessed before they moved into the home. They told us

they had discussed the care they would need. They were not sure if they had been involved in care reviews since they moved into the home. However, a relative told us they were involved in all aspects of care.

Personal life histories were completed and these provided detailed information about people's previous life and lifestyle, interests, likes, dislikes and preferences. Staff told us how this information helped them to build relationships with people who may not be able to communicate or recall their past experiences. A member of staff commented, "I always read the histories and talk to people. People's life histories can affect the way they act now".

An activity programme was in place, however, the activity coordinator was on holiday during the time of our visit. During the day of our visit, the area of the home that provided care for people living with dementia was lively and people were engaged in various activities throughout the day. It was evident that staff knew each person well. There was a collection of age appropriate puzzles, jigsaws and books. There was laundry that some people enjoyed folding, and a collection of colouring and painting materials. Staff knew what each person was most likely to prefer doing and people were offered the opportunity to do what they enjoyed.

In the other area of the home people were not so occupied until the part time activity coordinator was on duty in the afternoon. During the morning people spend time in the lounge, their bedrooms and some people sat in the reception area of the home. One person told us, "No there's not much to do. I just sit here because at least I can see people coming and going". During the afternoon, the activity coordinator played board games with people. People who stayed in their rooms were not offered or provided with any activity or engagement other than when staff visited to provide personal care. A relative told us entertainers sometimes visited the home and that people enjoyed those visits. They told us that no matter how poorly their loved one was, they enjoyed listening to music.

Most people we spoke with told us they would feel comfortable raising a complaint or speaking with a manager if they had any concerns. Comments included, "You have to tell the nice man if you have any problems. If they can they will make it better. They will listen and be with you all the way" "I do not have any concerns here. I would probably tell my daughter if I did, but there is nothing here to worry about" and, "I would be happy to share any concerns with any member of staff should I have any".

We discussed recent concerns that had been raised by a relative. The manager at the time and a member of the management team had met with the relative and actions had been taken. However, one of the managers' checked and the concerns, details of the meeting and agreed actions had not been recorded in line with the provider's complaints policy.

We checked other complaints records and found there was a clear record of the nature of concerns raised, the actions taken, and for one complaint, a lessons learned section had been completed.

Requires Improvement

Is the service well-led?

Our findings

The people we spoke with were not aware of the management arrangements in the home. The provider's website and statement of purpose stated the name of a manager who was no longer in post.

There had been no registered manager in post since the service was reregistered in July 2016. The current management arrangements, agreed the week before our visit, were that one of the provider's residential care experience specialists was acting as a full time 'interim manager'. They were supported for three days each week by another residential care experience specialist. The area manager provided additional support each week.

We spoke with the area manager, the resident experience care specialist and the interim manager about quality assurance systems that checked the quality of the service provided and helped to ensure risks to people's health safety and welfare were monitored. We checked the records and established the provider used a range of auditing and quality monitoring systems.

These included planned monthly audits of care plans, health and safety, housekeeping, falls, pressure ulcers, weight loss. For medicines management there was a system in place for weekly and monthly audits. The completion of audits was then checked using a Regional Manager TRaCA system. We found some of the TRaCA's did not provide accurate information. For example, a TRaCA was completed on 11 July 2017. In response to the question, 'Has the home completed relevant medication audits within the last 4 weeks and have all audit issues and actions over 7 days old been resolved' a 'Yes' response was ticked. There was also a narrative that stated, 'Some of the actions are not resolved'. After our visit, we asked the interim manager for copies of the actual audits referred to. We were not provided with this information. The interim manager told us there were no medicines audits completed for June or July.

The systems in place had not identified or had not addressed the shortfalls we found, for example, in medicines management and personalised care planning.

The above was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Resident and relative meetings had not been held for several months. However, people were given the opportunity to express their views and feedback was sought with resident and relative online feedback questionnaires. The focus of questions changed every three months and the focus from the questionnaires we looked at related mainly to food provision. The feedback was positive. This was not reflective of our findings when we spoke with people and received mixed feedback. One person told us that they were also asked, "Now and again" for their views. The person thought they were just asked about their views on the quality of food provided.

Staff told us they were kept informed and updated about management changes in the home. They told us, "We don't have a manager again. They come and go. I don't know why they don't stay. Sometimes we feel

insecure, but other management do come in and support us" "Morale is rubbish. We have no motivation, it's so frustrating" and, "I love it here, but we've had three managers in less than a year."

Staff meetings were held to make sure communication was effective throughout the home. In addition daily 'stand up' meetings were held with staff representatives attending from each department. Each member of staff provided an update from their department and an overview was provided by the person in charge.

The managers understood their responsibilities with regard to the notifications they were required to send to the Commission.

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 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 9 HSCA RA Regulations 2014 Person-centred care Peoples' care and treatment did not always meet their needs Regulation 9 (1) (2) (b)

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 Medicines were not always safely managed. Risk management was not always sufficient and did not always mitigate risks to people's safety. (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems did not always assess, monitor and mitigate risks or make improvements to the quality of the service. Regulation 17 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive on-going supervision to make sure they were competent

Treatment of disease, disorder or injury

to carry out their roles.

Regulation 18 (2) (a)