Care UK Community Partnerships Ltd

Addington Heights

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

This was an unannounced inspection that took place on 12 and 13 January 2016.

Addington Heights is a residential care home and respite unit that provides accommodation and personal support for up to fifty older people who have a range of nursing, and other care needs associated with old age. The service is separated into five clusters that can accommodate a maximum of ten people. Each unit specialises in providing care to people with either nursing, residential or respite needs. The units are self-contained and each have their own lounge and open plan kitchen/dining areas.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

In September 2014, our inspection found that the home met the regulations we inspected against. At this inspection the home did not meet all the regulations.

People and their relatives told us the home provided a relatively good service, the environment was comfortable and they liked living there. They found that staff were caring, attentive and provided the care and support they needed in a friendly and kind way.

The staff team experienced a turnover of staff which meant people experienced further changes in personnel. Staff supervision and training arrangements did not provide staff with appropriate support, training and development. The service needed improvements in this area and was in breach of regulation.

The records were comprehensive; the electronic (Caresay) and paper records were used. They contained clearly recorded, fully completed, and regularly reviewed information which enabled staff to perform their duties well. However, on one unit we found that some important information was misfiled which meant this information was not shared in a timely manner with relevant professionals which may have had a negative impact on people.
People and their relatives were encouraged to discuss health needs with staff and had access to community based health professionals, as GPs as required. There were improvement to how people had their healthcare needs promoted, for example the introduction of a weekly surgery by the GP and improved communication with healthcare professionals.

People were protected from risks associated with nutrition and hydration and had balanced diets that also met their likes, dislikes and preferences. People and their relatives were positive about the choice and quality of food available.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The registered manager was aware and had made referrals when required, but told us no one at the home was subject to any restriction under the DoLS guidelines. Staff understood how to support people to make choices.

The home was well maintained, furnished, and clean and provided a safe environment for people to live in.

People's social needs were not fully met. The service failed to give people enough opportunities to participate in meaningful social activities, and many spoke of being bored and a need to improve provision in this area. The service needed to improve in this area and was in breach of regulation.

The majority of staff were knowledgeable about the people they worked with and about the care field they worked in, there was a lack of consistency on four of the units because care staff were continually rotated, this prevented staff developing beneficial relationships with people.

Relatives said the management team at the home were approachable, and mostly responsive. However two of the relatives commented that they have raised the same issues on several occasions in the past twelve months which indicated that the provider was not listening to their views.

The service has experienced instability in 2015. The registered manager left in early 2015 after having been in post only a short time. We found that the interim management system had not been effective in addressing shortfalls. The interim management had failed to thoroughly review practices at the home, and had not identified the shortfalls in staff training and supervision, care delivery. The newly appointed and registered manager had been in post for a short period. The operations manager and manager acknowledged these shortfalls and told us they were addressing them.
The service was in breach of three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the staff training and support, a lack of opportunities for people to engage in stimulating activities, inconsistent management and ineffective quality assurance processes in the service. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe.

People said they felt safe. They were protected from abuse by effective safeguarding and risk assessment procedures. The planning and delivery of care was managed in a way which mitigated risks to the health and welfare of people.

The home had employed appropriate numbers of staff. The service recruited staff who were suitable for the roles. People received medicines as prescribed, and medicine records were up to date. Medicine audits and checks were completed on a regular basis to ensure procedures operated were safe. Medicines were safely stored and disposed of.

Is the service effective?

Requires Improvement

The service was not always effective

The training and supervision arrangements deteriorated and were not delivered consistently in the past twelve months and this impacted on staff development, skills and practice.

The Mental Capacity Act (MCA) 2005 and its Code of Practice was used effectively. The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Training was provided for staff according to roles and responsibilities. People underwent mental capacity assessments.

People received the care and support they needed from staff. Their care plans monitored food and fluid intake and balanced diets were provided.

The home was decorated and well presented to meet people's needs and preferences.

Is the service caring?

Good

The service was caring.

People felt valued, respected and were involved in planning and

decision making about their care.

Staff knew people's background, interests and personal preferences well and understood their cultural needs. They provided support in a kind, professional, caring and attentive way that went beyond their job descriptions. They were patient and gave continuous encouragement when supporting people.

The care was on occasions task driven and not always centred on people's individual needs.

Is the service responsive?

Requires Improvement

The service was not responsive.

The support arrangements to meet people's social care needs failed to consider their individual needs and preferences. There was a lack of stimulating activities to choose from, and people were not always able to engage in activities and tasks they liked or which complemented their abilities.

People had their support needs assessed and care plans identified the support they needed and it was provided. People told us that any concerns raised with the home or organisation were discussed and addressed as a matter of urgency.

Is the service well-led?

Requires Improvement

The service was not well-led.
Interim management arrangements when there was no registered manager present did not provide the leadership and stability required. People who use the service and relatives said they felt their views were not listened to during this period. These had also contributed to low morale and a lack of motivation in the staff team, but signs were this recently improved.

Quality control processes were not robust. A range of checks and audits were undertaken but these failed to monitor and identify shortfalls in people's care, also in the provision of staff support and training. Under the new registered manager there had been signs that some of the changes made were contributing to more positive outcomes for people especially in relation to healthcare.

Addington Heights

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 checked 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.

We inspected the service on 12 and 13 January 2016. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. The inspection team consisted of an adult social care inspector and a specialist advisor for older Adults and dementia care.

Before the inspection, the registered manager was asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make, this information was returned on time.
We considered the inspection history, notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider. We also contacted monitoring officers who visit the service, and commissioners who are involved in placing people who used the service.

At the time of our inspection visit there were 40 people present who used the service, one person was in hospital. We spent time and spoke with 20 people who used the service and eight visiting relatives. Following the inspection visits we spoke with three more relatives on the telephone. We spent time in the communal areas and observed how staff interacted with people.
During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and home's maintenance and quality assurance systems.

We looked at the personal care and support plans for five people living at the home, and staff records for four members of staff recruited in 2015.
We spoke by telephone with three health professionals involved with the care of people who use the service. We contacted commissioners and the monitoring officer to get more information about the service.

Good

Is the service safe?

Our findings

People and their relatives said they found the service was safe. One person told us, "It is a safe environment; you always have a staff member about to come to your aid." Another person said, "I have no problem with the staffing levels." A relative said, "I am not sure if there are sufficient staff on duty at night, numbers are less."

Staff had received safeguarding training and were aware of how to raise a safeguarding alert and the circumstances under which this should happen. Safeguarding information was provided with local authority contact numbers on display. Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from. The home had policies and procedures regarding protecting people from abuse and harm. We asked staff to explain their understanding of what abuse was and the action they would take if they were confronted by it. Their response met the provider's policies and procedures. Our discussions with care staff demonstrated they had a good working knowledge of their responsibilities to protect vulnerable people from abuse. They said protecting people from harm and abuse was part of their induction and annual refresher training. Relatives said they had never witnessed bullying or poor practice at the home.

People's care plans contained risk assessments that enabled them to take acceptable risks and enjoy their lives safely. The identified areas of risk depended on the individual and included issues such as skin integrity, mobility, nutrition and health needs. Staff at the service used recognised assessment tools for looking at areas such as nutrition and tissue integrity. We saw where risks had been found, risk reduction strategies had been identified. Staff knew who was at risk of falling and we saw they were present in communal areas to support and encourage people use the walking frames and remain safe when walking. For example one person had been identified as at risk of falls. Care records showed the person falling earlier in the year but due to memory lapses they tended to forget to use their walking frames. There were risk assessments for aspects of people's daily living including moving people safely and use of hoisting equipment. We saw that care plans clearly detailed the number of staff required to use the equipment supplied to move people safely. Staff were trained in moving and handling procedures and where staff were not up to date training directives were issued to them advising they could not continue to work until this this training was up to date. We saw that the management team had addressed with staff the importance of using the equipment to do the task safely. Staff were aware of the risks associated with individuals and how these were increased if they did not follow the guidance. The care plans contained plans to help prevent accidents such as falls from being repeated. The risks were reviewed regularly and updated when people's needs and interests changed.

The home and grounds were well maintained and equipment used was regularly checked and serviced. Another organisation known as Eldon Housing took responsibility for the maintenance of the environment and housekeeping. They completed generic risk assessments and fire risk assessments. The fire risk assessment presented for the premises was dated as due for review in November 2015. Later in the day we received an up to date version of the fire risk assessment. We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the fire alarm, fire extinguishers,

emergency lighting and hard wiring.

The information recorded for handovers showed staff shared information within the team regarding risks to individuals. This included passing on any incidents that were discussed at shift handovers and during staff meetings. There were also accident and incident records kept and a whistle-blowing procedure. It was noted that despite attending training some of the more junior staff were unsure about using Whistleblowing procedures. The registered manager had booked staff to attend refresher training for 2016.

Staff recruitment procedures recorded all stages of the appointment and selection process. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the home. References were taken up prior to starting in post. We drew to the attention of the registered manager that two of the references seen on files staff showed minor discrepancies in relation to the person's employment history. The application form contained details of all previous employment, but the professional references were not provided by the previous employer and the reason was not recorded. There were records of face to face interview which contained questions to identify people's skills and knowledge of the client group they would be working with. There was also a six month probationary period, during which new staff shadowed experienced staff at commencement. The home had disciplinary policies and procedures that were contained in the staff handbook and staff confirmed they had read and understood them. We saw examples of the organisation taking action and following disciplinary procedures as relevant to deal with competency and capability issues.

People and their relatives told us they thought there were enough staff to meet their needs. There were suitable numbers of staff on duty when we visited to meet people's needs and the numbers of staff on shifts during the inspection matched those on the staff rota. Staff reported difficulties at weekends with staff informing the service at short notice that they were unavailable to work. The registered manager told us that when possible they engaged replacement staff from bank team or agency staff to cover the short term vacancy. Having looked at staff rotas we saw some evidence of reduced levels of staff at weekends, however one of the units had just one person and were awaiting referrals for admission. Staff from this unit were deployed on other units. This allowed staff to meet people's needs in a safe, unrushed way.

The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. The medicine records for people using the service were checked and found to be fully completed and up to date. Medicine kept by the home was checked and audited daily. Medicine audits were also completed weekly; any medicine errors were reported on and investigated fully. The drugs were safely stored in a locked facility and appropriately disposed of if no longer required. The service had procedures in place for ordering and requesting new supplies of medicine. However this process had recently been changed to ordering supplies electronically and staff found it unsatisfactory. The registered manager had arranged a discussion with the pharmacist to resolve the issues.

Requires Improvement

Is the service effective?

Our findings

We found that the systems in place for managing and overseeing staff training were ineffective for the past twelve months and as a result staff had not all kept their professional development up to date. Nurses training and development was not up to date including first aid training. Carer's training in dementia and other mandatory training showed gaps and some mandatory training was overdue. The operations manager and manager recognised the shortfalls and were taking action to address these gaps but realised it would take time to ensure all of the staff completed the necessary training. Two of the most recently recruited staff told of their induction, they found it thorough and useful for their roles. They shadowed senior experienced staff for the first two weeks, and completed all mandatory training. They both had completed their induction programme and a satisfactory probationary and had this signed off by the manager.

We saw that the provider had introduced a new appraisal system for staff. But supervisions and appraisals had also lapsed in 2015 with the exception of staff working on the nursing unit. These shortfalls occurred when there were was no permanent manager in post. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The manager and operations manager were aware of this and plans had begun to address the shortfalls.
The service failed to provide staff with appropriate training and support, this was a breach of 18 (2) (a) (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we observed people made decisions about their care and what they wanted to do. Staff were aware of people's needs and how to meet them. They provided a comfortable, relaxed atmosphere that people enjoyed. People said they made their own decisions about their care and support and that their relatives were also able to be involved. People and their relatives said the type of care and support provided by staff was what they needed. One person told us, "It is a good place to be when you can no longer manage in your own home, I am quite independent but they (staff) help me with things I cannot do for myself such as helping me with a bath." Another person (relative) told us, "A good service despite a turnover of carers, staff ensured my family member settled in well and was made feel part of the group." The registered manager told us of future plans for enabling people to be more independent and to involve staff in rehabilitation training.

Staff received mandatory training in The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Mental capacity was assessed as part of the assessment process to help identify, plan and provide for individual needs .The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Required applications under DoLS were submitted by the manager. The registered manager had submitted an application for one person to the supervisory body (local authority) for authority to deprive a person of their liberty. A psychiatrist came to the home to assess the person; however this was not approved.

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Care records showed that meetings took place with family members to determine the best course of action for people who did not have capacity in specific areas to make decisions for themselves. The capacity assessments were carried out by the manager or senior staff that had received appropriate training; these

were recorded in the care plans. Some people were unable to manage their own finances. We saw from care records that people had appointed attorneys by way of a lasting power of attorney (LPA). Care plans recorded where attorneys had been involved in decision making or where reviews of care plans had been undertaken.

We looked at a training chart which indicated that all staff had participated in training in the Mental Capacity Act (MCA) 2005, but only more senior staff had attended advanced training in MCA and DoLS. Junior staff had received e learning training on mental capacity but in our discussions they demonstrated they did not fully understand the referral process. The registered manager was aware of the need to ensure that all staff receive this training.

We saw care plans recorded when someone had made an advanced decision on receiving care and treatment. The care files in the nursing unit held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff, who were aware of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital. A relative we spoke with told of being consulted and involved in discussions with staff about their family member's advance care plans.

Individual's records included plans for managing nutrition and hydration. These included the use of a 'Malnutrition Universal Screening Tool (MUST) that was monitored and updated regularly. As required weight charts were kept and staff monitored how much people had to eat and drink. There was information regarding the type of support required at meal times. We saw evidence of good practice as staff assisted people at mealtimes. Nutritional advice and guidance was provided and staff involved health care professionals such as dieticians and speech and language as required. The records demonstrated that referrals were made to relevant health services as and staff liaised effectively with external professionals. Staff said any concerns were raised and discussed with the person's GP. It was recognised that there were improvements in how healthcare was promoted. Since August 2015 there was a GP surgery held at the home weekly and the GP undertook more frequent visits if required. People told us the weekly visits from the GP had contributed to improvements in their healthcare provision. It also meant that some people could choose to retain their own GP if they preferred. The scenario based recruitment interview questions included prospective candidates knowledge and importance of nutrition and hydration. A GP informed us the regular weekly visits had helped improve communication with staff at the home.

The feedback on food served was positive and people told us they enjoyed the meals provided. Another organisation was contracted for the catering provision. A person using the service said, "The meals are quite good and you have choice." Another person spoke of the food being bland. A relative told us, "I visit often and the food always looks and smells lovely." During our visit people chose the meals they wanted. There were two choices available, the meals were of good quality and special were provided for. Two people talked of "less choice" in recent months and of processes changed and a reduction in menus. It was not clear how effective the communication between care home staff and kitchen staff was about individual likes and dislikes. These were shared with care staff and recorded in care records. A person told us they expressed they disliked to staff on more than two occasions the foods they did not like. Despite sharing this information staff had served the food specified in their food preference record. The service had begun to hold for each person what was called a resident's day in which a member of the catering staff were invited to find out the person's likes and dislikes. However this seemed to lack consistency and it was unclear from records that this took place, and staff were unable to verify this event either. Kitchen staff told us they were given a list of the specialist dietary needs of people. A relatives meeting was scheduled for the week after the

inspection, and people told us they planned to discuss menu planning with management at the meeting. The lunch we saw both days was well presented, nutritious and hot. Meals were monitored to ensure they were provided at the correct temperature.

Good

Is the service caring?

Our findings

One person said, "The care is good here. The majority of staff are kind and caring." A visiting family member said, "I do find staff are generally pleasant and approachable and have a good attitude to the work." The records we saw and information from management showed that staff who did not follow codes of conduct were managed appropriately and disciplinary measures were used to address poor practice.

One carer we interviewed told us, "I like to work in a person centred way". They had an interest in different cultures of residents and always asked them to choose which clothes they would like to wear and she likes to take time with their care needs.

Staff were familiar with people, knowing their needs and preferences very well. People were treated equally, with compassion and staff talked to them as their equals. People were addressed at eye level and open, suitable body language was used by staff to communicate messages to people who had hearing or cognitive difficulties. We saw that staff listened to people and acted upon what they were being told. The caring approach of staff was supported by their understanding of the person obtained from their life history and care plans. People's records included information on race, religion, disability and beliefs. This information enabled staff to respect them, their wishes and meet their needs. In some care plans we reviewed there was information recorded on the person's preferences regarding end of life care.

People were comfortable, well dressed and clean which demonstrated staff took time to assist people with their personal care needs. We saw that staff paid attention to nail care; some people were assisted by staff to paint their nails. However it was unclear if people were offered daily or weekly showers and care plans did not specify any preferences regarding frequencies. We spoke with one person who had chosen to remain in their room and looked very comfortable. They said, "I am well looked after here, I like to stay in my room and staff respect my choice." A person who came to the home for respite care told us, "It has been a pleasant stay; staff have made me welcome and made sure I was comfortable."

People and their relatives told us that the service treated them with dignity, respect and compassion. The staff made an effort to ensure people's needs were met and this was reflected in their care practices. People said they enjoyed living at the home and were supported to do what they wanted to. Staff listened to what people said, their opinions were valued and we were told staff were friendly, patient and helpful. We saw how staff treated people with dignity and respect. They were attentive and patient and interacting well with people. Staff were friendly and acknowledged people with smiles or a comforting hand on their shoulder. People were treated equally, with compassion and staff talked to them as their equals. The speech of staff was unhurried so that people could follow what they were saying and understood. People were addressed at eye level and open, suitable body language was used by staff to communicate messages to people who had communication difficulties. We saw that staff listened to people and acted upon what they were being told. The caring approach of staff was supported by the life history information contained in care plans that people, their relatives and staff contributed to and regularly updated. People's personal information including race, religion, disability and beliefs was also clearly identified in their care plans. This information enabled staff to respect them, their wishes and meet their needs.

The environment was well laid out; it supported people's privacy, confidentiality and promoted their independence. The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on-going training and contained in the staff handbook. There was a policy regarding people's privacy, dignity and right to respect that we saw staff following throughout our visit. They were very courteous, discreet and respectful even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us that there was very little in the way of activities, and that they felt they were not getting stimulation and were bored. One person said, "You get fed up sitting here. There's nothing going on." We saw another person who remained in their chair all day except for short periods when they got up to use the bathroom. In the dining rooms we observed music was played during mealtimes, however in one unit the music playing was not age appropriate or according to the taste of people, one person said," "I do not like Beep pop music."

A relative we spoke with said they had not seen many activities taking place and cited boredom as the main problem for residents but commented that the overall care was good. Over both days of our visits we observed that people were offered insufficient stimulation. Some people received one to one attention on our first day and had hand care and their nails painted. There was no structured activity otherwise and carers did not organise any events or sit with people to find out if there was any activity they wished to pursue. The failure to provide individuals with opportunities for suitable stimulation was a breach of Regulation 9(3)(b) HSCA RA Regulations 2014.
A person using the service said, "Fortunately a number of people are from the local community and a number of our relatives and friends visit most days." We spoke with a number of people visiting, they told us family members visited frequently, and they participated and engaged with people sharing afternoon teas. The service had responded to requests people had made regarding refreshments, for example a supply of snacks was made available outside of mealtimes in the evenings.

A new activities coordinator was appointed recently. We spoke with her and she showed us plans for developing suitable activity planners including establishing links with local churches and schools. She worked five days a week including alternative Saturdays. This helped ensure that people who did not have visitors over the weekend were offered some kind of recreational interest. Some of the previous activities described by people as enjoyable such as musical movement were no longer taking place, and nobody could explain why the sessions were cancelled. There were no puzzles or books on display for people, although some people we spoke with enjoyed reading the daily newspaper or a book. We noted too that information on personal histories was limited for some people, and for those on respite there was a distinct lack of information on their likes dislikes and hobbies and interests.

Prior to moving in people were provided with written information about the home and what care they could expect. People, their relatives and other representatives were consulted and involved in the decision-making process. They were invited to visit if they wished before deciding if they wanted to move in. Staff told us the importance of considering people's views as well as those of relatives so that the care could be focussed on the individual. One person visiting said "I knew this was where I wanted my family member to be cared for, this is the best and it is local."

People were referred by the local authority who also provided assessment information. This information was shared with the home's management team to identify if people's needs could initially be met. The home then carried out its own pre-admission needs assessments with the person and their relatives. This covered

areas such as personal information, medical and psychological history and current medication. On occasions in the past the home has accepted people whose needs they could not fully meet and as a result people have had to be transferred to more appropriate accommodation. The registered manager told of the negative impact on the person of admitting people who were unsuitable, there were more rigid plans in place to prevent any further inappropriate admissions.

Most of the people we spoke with said they were happy at the service and felt staff responded appropriately to their care needs. People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and investigating complaints. On looking at the complaints log, speaking with people and relatives we found that complaints made were generally acted upon promptly and learnt from with care and support being adjusted accordingly. There were some negative experiences during the period when the interim management arrangements were unsatisfactory.

We saw that meetings were scheduled for people who used the service and for relatives. People told us they were looking forward to the opportunities to feedback on issues where they would see improvements.

Requires Improvement

Is the service well-led?

Our findings

The information we gathered, the feedback from people using the service and their relatives demonstrated the service was not always well led. The previous registered manager departed in early 2015. In the interim instability and inconsistency for a part of 2015 contributed to deterioration in the service which was still not addressed. During this time arrangements were unsatisfactory for monitoring aspects of financial procedures. As a result of lessons learned the financial procedures have now been strengthened and we saw that new procedures were monitored more robustly by two people.

Staff had felt unsupported and were not always supervised, and their training needs were not provided for. The registered manager explained why some routines were changed to effectively manage the service. One member of staff said, "It is good now the new manager will always advise you that your training is due for renewal, and you are not able to work if mandatory training is not up to date."

We saw during the inspection that some records were not always appropriately kept and information was, on occasion, misfiled and practices within the home varied. Fluid and food charts were completed accurately, and we saw that management visits out of hours audited these. When not completed correctly in recent months records of staff meetings showed these shortfalls were addressed with staff. On each unit there was a diary book held for doctors and professionals appointments, but some units did not record the appointments and there was confusion among staff about practice. The deputy manager/clinical lead maintained a complete list of all people attending appointments and these were accurately recorded. On case tracking individual's care we found some paper care plans and reports were not always filed correctly or securely and it was difficult to easily access important information. Electronic records called Caresay were completed, however important information regarding contact with GP and updates, personal care and podiatrist appointments were not always recorded. These shortfalls in practice had the potential to place people at risk of receiving poor and inconsistent care.

People and relatives told us of their frustration with how the service was managed before the registered manager was appointed. Three relatives told us they had raised the same issues with operations managers on more than one occasion but these were not responded to and kept reoccurring. One relative said, "I have explained time and time again that my relative is unable to manage mail independently and I need to be aware in case there is some important mail missed, but despite this I have not been made aware of important letters that arrived."

A range of checks and audits were undertaken but these had failed to monitor and identify any of the shortfalls in the service or regarding the provision of staff support and training. The lack of consistent management meant there were ineffective systems for assessing, monitoring and improving the quality of the services provided; this was a breach of Regulation 17 HSCA RA Regulations 2014.

Staff felt the lack of management support when there was no registered manager had contributed to low staff morale and a lack of motivation in the staff team, but that this had recently improved due to the presence of a registered manager.

There were now regular staff meetings held, and daily briefings between team leaders and the clinical lead of ten minutes. However we saw that these took much longer than planned and reduced the staffing levels on the units. We saw that regular management meetings were scheduled with people who used the service and relatives. There were some positive changes to the service. Health professionals told of improvements in relationships with the staff at the home and of more effective communication with staff. Another healthcare professional also said these changes in care arrangements contributed to improved outcomes for people who used the service.

The quality assurance, feedback and recording systems covered all aspects of the service constantly monitoring standards but these had not always been followed up to drive the improvements required. We saw that action plans were developed with area managers to respond to all areas of shortfall; however it was unclear what timescales were set for achievement.

Relatives told us there was an open door policy that made them feel comfortable in approaching the manager. One person told us, "The manager is approachable and could not do enough for you and is always available to discuss any issues." One relative commented they would like to see the manager present more on the units to observe practice.

There were clear lines of communication within the organisation and specific areas of responsibility and culpability. There was a whistle-blowing procedure that staff said they would be comfortable using. They were also aware of their duty to enable people using the service to make complaints or raise concerns.

Despite inconsistent management arrangements in the past records showed that safeguarding alerts, and accidents and incidents were fully investigated, documented and procedures followed correctly. Our records showed that appropriate notifications were made to the Care Quality Commission in a timely way.
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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	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of opportunity for people to engage in a range of stimulating activities that met their social and cultural needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective monitoring systems to oversee the service. Provision for monitoring of supervision and staff training were ineffective as staff were not up to date with their training. Audits and checks did not identify all the shortfalls in the service such as those highlighted in financial procedures, management of up to date care records. Action plans developed were not fully implemented within timescales to drive the improvements needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably trained to enable them to carry out the duties within their role. Staff were not appropriately supported, supervisions and appraisals were not up to date.