Selly Park Healthcare Limited

Selly Park

Inspection report

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Ratings

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

Overall summary

This inspection took place on 22 and 23 October 2015 and was unannounced. We had not inspected this service since there had been a change of legal provider in August 2014.

Selly Park is a residential home which provides nursing care to older people most of whom are living with dementia. The service is registered with the Commission to provide accommodation and personal care with nursing for up to 50 people and at the time of our inspection there were 36 people using the service. There was a registered manager at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The registered manager had conducted assessments to identify if people were at risk of harm but people's care records had not always been updated as their conditions

Summary of findings

changed. The lack of current and accurate records about support that was to be provided placed people at risk of receiving incorrect support. You can see what action we told the provider to take at the back of the full version of the report.

Several people said they were bored because staff were too busy to sit and help promote their interests. The registered manager had failed to identify that current staffing arrangements and deployment had a detrimental impact on the safety and well-being of people using the service. You can see what action we told the provider to take at the back of the full version of the report.

Staff we spoke with could recognise the signs of abuse and could explain the process they would take if they felt a person was at risk of abuse. The provider and registered manager did not always take action when they received information of concern.

The registered manager did not ensure the premises were managed appropriately to keep people safe. Medicines were mostly managed safely.

Staff were knowledgeable about the requirements of seeking consent however The registered manager had not considered each person's individual support needs or assessed if any less restrictive alternatives were available. You can see what action we told the provider to take at the back of the full version of the report.

Staff were supported to maintain their skills and knowledge through regular training. However staff did not always follow directions left by visiting health care professionals.

Menus reflected people's preferences and drinks and snacks were available throughout the day.

People gave us mixed feedback about how they were supported to access additional health care services when they needed them.

The provider did not promote a positive culture which was person centred. Many people told us that staff were focused on completing tasks instead of responding to people's requests for support and promoting a homely atmosphere. The care and support provided to meet people's health care needs failed to consider their individual welfare and preferences. You can see what action we told the provider to take at the back of the full version of the report.

The provider had a complaints process which was displayed around the home. A complaints log was not always completed sufficiently to identify how incidences could be prevented from happening again.

The provider's processes for monitoring and improving the quality of the service were not robust and had not identified several failings at the service. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. The staffing arrangements and deployment of staff failed to ensure that staff were available in sufficient numbers to meet people's needs.

People were at risk of receiving unsafe or inappropriate care because records had not always been updated as people's conditions changed.

People were at risk of receiving support from people who were not suitable to support them.

Requires improvement

Is the service effective?

The service was not effective. People were not always supported in line with the Mental Capacity Act 2005.

Meals times were not a pleasant and sociable experience as people had to wait for support. People were involved in choosing what they liked to eat.

Staff had received training in the skills they required to meet people's care needs. However staff did not always follow the advice of other health care professionals.

Requires improvement

Is the service caring?

The service was not caring. Staff did not respect people's privacy.

Staff did not spend time with people and did not promote people's social inclusion and well-being.

Requires improvement

Is the service responsive?

The service was not responsive. The care and support provided to meet people's health care needs failed to consider their individual needs and preferences.

People were not always supported to engage in activities and tasks they liked or which complemented their abilities.

Requires improvement

Is the service well-led?

The service was not well-led. Quality control processes were not robust and were unclear and failed to identify issues that needed to be addressed.

The registered manager did not always fulfil their legal obligations to make notifications to the Commission.

The provider did not promote a clear organisational and management structure.

Requires improvement

Selly Park

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days in October 2015 and was unannounced. On

22 October the inspection team consisted of two inspectors with partial support during the day from a third inspector. A specialist advisor was also in attendance who had clinical knowledge of the needs of the people who used this type of service. On the 23 October the inspection team consisted of one inspector with the support of another inspector for part of the day.

Before the inspection we asked the provider 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 and we took this into account when we made the judgements in this report. We also checked if the provider had sent us any notifications. These are reports of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We used this information to plan what areas we were going to focus on during our inspection.

During our inspection we spoke with eight people who used the service. We spoke with four relatives and friends who were visiting people who lived at the home. We also spoke to the registered manager, the deputy manager, the provider's quality control lead, two nurses, six members of care staff, an activities co-ordinator, the head cook, kitchen assistant and a domestic assistant. We spoke to a GP who was visiting to support people who used the service. We also spoke with an external training provider who was delivering training to staff. We looked at records including seven people's care and medication records. We looked at two staff recruitment records and staff training records. We looked at the provider's records for monitoring the quality of the service and how they responded to issues raised. We 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.

After our inspection we were supported by an expert by experience to speak with and seek the views of the relatives of six people who used the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We also spoke to one person from the local clinical commissioning group who monitor the quality of the service and a person from the local authority who commissions care packages for people from the service.

We also reviewed details of concerns we had recently received about the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with said they felt that they were safe and staff could take action if they felt people were at risk of harm. However several people suggested they were not confident that this action would be prompt.

Staff we spoke with could recognise the signs of abuse and could explain the process they would take. Information we received prior to our inspection showed that the registered manager took action when people were thought to be at risk of harm although records we saw whilst carrying out the inspection indicated that this did not happen consistently. For example when a pharmacy supplied the incorrect medication to a person the registered manager took action to protect the person from harm and prevent a similar incident from reoccurring. However concerns raised by members of staff about people's safety and the provider's recruitment practices had not been responded to.

The provider had conducted assessments to identify if people were at risk of harm and how this could be reduced. Staff we spoke with were knowledgeable about the risks presented by people's specific conditions and how they would manage these risks. People's care records had not always been updated with new guidance for staff as people's conditions changed. For example the records for a person with a specific condition had not been updated with important advice from a visiting clinician. Records for another person had not been updated when their medication was changed after returning to the service from hospital. The lack of current and accurate records about support that was to be provided placed people at risk of receiving incorrect support. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us that there were not always enough staff to support them when required. A person who enjoyed sitting in the garden told us they often ended up becoming cold because they waited longer than they wanted before a member of staff was available to support them to go back into the building. Several people told us that they found the home boring because staff were too busy to sit and interact with them. One person said, "Staff just walk right past me." We observed two people regularly trying to catch the attention of staff walking past them. They were not acknowledged by staff. One person said, "That's it, I give in," and the other said, "I give up, there's nobody." The issues about the lack of available staff and the impact this had on the safety and well-being of people using the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A review of the recruitment records of two people who had recently started working at the service showed that the provider had not obtained a reference from one person's most recent employer or conducted an appropriate police check. The registered manager had not undertaken checks that staff employed at the provider's other locations had the competences, skills and experience necessary to meet the specific care needs of the people who used the service. This meant that the provider had employed people who may not be suitable to safely support the people who used the service. Failure to have effective recruitment processes is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the relatives we spoke with told us that they felt there were not enough staff to meet people's care needs. Comments from people's relatives included, "Sunday staff are quite sparse. There aren't enough staff;" "There appears to be not enough staff. Sometimes they're preparing food and there's no one actually there with the residents;" "Staff always seem to be rushing around;" and "You can never phone at night because they'll never answer."

All the staff we spoke with felt they did not have enough time to fully meet everyone's care needs. A member of staff told us, "We definitely need more staff, that's the biggest problem." Another member of staff said, "I don't have time to sit with people until about seven [7 pm] when some people have gone to bed and it's quieter." A member of staff told us that, "People stay in bed too much. We don't always have time to get people out of bed." Staff we observed appeared busy and did not spend time promoting social interaction when providing personal care or helping people to engage in individual activities. We regularly noted that staff were not always present in communal areas to respond to people's requests for support. On several occasions members of the inspection team were required to intervene and seek out staff to support people. This included asking staff to support people with drinks and going to the toilet. The registered manager told us there should always be a member of staff "floating" between the two lounges but we saw this did not always happen.

Requires improvement

Is the service safe?

The registered manager told us that they altered the number of staff on duty in response to the number of people using the service. However there was no formal process to calculate the number of staff required and was based on the registered manager's individual judgement. The registered manager was preparing to admit three new people into the home the following week but there were no clear plans to indicate how staffing levels had been assessed or would be adjusted to meet the needs of these additional people.

The registered manager did not ensure the premises were managed appropriately to keep people safe. We found several doors unlocked which exposed people to the risk of harm. Doors to a cupboard which contained cleaning products and another which contained alcohol were unlocked which meant that people were at risk of swallowing liquids which could harm them. A door to the cellar was unlocked and lead to steep stairs which could be a trip hazard. A door to the attic was unlocked which again exposed people to the risk of steep stairs. The attic rooms were used for storing maintenance equipment and surplus or broken furniture and fittings. This made the attic rooms a potentially hazardous environment. These rooms were not routinely visited by staff which meant that if a person became disorientated they could remain lost for a significant amount of time. The registered manager told us these doors should have been locked. However we noted that some of these doors still remained unlocked on the second day of our visit.

We observed medications were administered by the nurses at the service. Both nurses we spoke with told us they received regular medication administration training at another location and felt confident to support the medication needs of the people who use the service. We saw that protocols were present for nursing staff to follow when administering medicines as required and there were no gaps in recordings of medicines given. Records were always signed by two members of staff to confirm that medicines had been given and a count of the controlled medicines showed the quantities held matched the nurse's records. This indicated people had received their medication as prescribed. We noted however that a medication which was applied by a patch to the person's skin had not been rotated as per the manufacturer's instructions. Records showed that staff had consistently applied the patch to the same site which may have affected the absorption rate/amount of prescribed medication the person received.

Medicines were securely stored in lockable trolleys or cupboards as appropriate in a dedicated treatment room. This kept people safe from accessing medication inappropriately.

Records detailing the temperature of a fridge used to store medication had not been fully completed and on one occasion showed that medication had been stored above recommended temperatures. The service could not evidence that medicines stored in the fridge had been kept at the correct temperature for approximately three months prior to our visit or that action had been taken when the temperature was found to be high. This meant that medicines stored in the fridge may not have been effective in controlling people's health conditions.

The provider did not have effective systems in place for consistently ordering and managing medication held in the home. For example on one occasion we saw that nurses were not administering the oldest stocks of eye drops and insulin first. This meant that stocks could exceed their expiry date before being used resulting in the service running out of these medications.

Requires improvement

Is the service effective?

Our findings

Staff we spoke with were knowledgeable about the requirements of seeking consent from the people who used the service although this was not always carried out. Staff told us and we saw that they had recently received training in the Mental Capacity Act 2005 (MCA). The 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.

The registered manager told us they involved people's relatives when making day to day decisions for people who lacked mental capacity. However they had not always sought confirmation from relatives and friends that they had the authority to make decisions on people's behalf.

The registered manager had conducted assessments when people were thought to lack mental capacity to identify how care could be provided in line with their wishes. However the registered manager had not always taken action to ensure that care and treatment people received did not restrict their movement and rights under the MCA. For example, some staff had positioned people in chairs which restricted their ability to move unaided and also moved some people's mobility aids out of their reach when they sat down. This prevented people from leaving their chairs if they wanted. A member of staff told us this was standard practice at the service in order to keep people safe from the risk of falling. The registered manager had not considered each person's individual support needs or assessed if any less restrictive alternatives were available. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we observed that staff did not regularly ask people if they wanted to be supported or how the support was to be provided. Staff were generally occupied with ensuring daily care tasks were completed and did not always seek consent before providing care. However we noted that when people expressed a preference that they were generally supported in line with their wishes.

Staff told us and records confirmed that staff received regular training to maintain their skills and knowledge. Staff received further guidance at supervision meetings although some staff said supervisions did not occur as often as they would like. All the staff we spoke with felt they had the necessary skills to support people who used the service. The registered manager told us they had introduced a series of training events at the service to ensure staff had the appropriate health and social care qualifications. Pre-arranged training sessions for staff occurred on both days of our inspection. An external training provider told us they regularly delivered training at the service and had developed individual development programmes for some staff. These were to support them to achieve social care qualifications and develop their basic maths and English skills. We saw that members of staff had undergone additional training when necessary so they could continue to support people as their care needs changed.

The registered manager told us and people confirmed that people had been involved in redesigning the service's menus to ensure they reflected people's preferences. The head cook at the service told us they were suitably supported by staff to ensure people had food and drink which met their nutritional needs. The head cook was aware of what people liked to eat and we saw that people were given meals they had specifically requested although they were not on the menu. We observed the kitchen staff approach people at the service to ask what they wanted to eat and if they were happy with the food. We observed one person was served a meal which was not of their liking and they exchanged their meal with another person without being offered an alternative choice by staff. Staff knew how people's food was to be prepared to reduce the risk of choking and we saw that food was prepared appropriately.

Staff did not promote meal times as a pleasant and sociable experience. There were no communication aids or menus in place to support people to express what they wanted to eat and drink. Staff told us they knew where people usually liked to sit to have their meals but we noted that they did not always check if this was what people still wanted. All the people who used the service were given drinks in cups with lids on, regardless of their personal choice or abilities. Condiments and sauces were available but most containers were dirty. There were not enough staff available to support people to eat together and we

Requires improvement

Is the service effective?

often saw people waiting for support to eat or requests for support going unanswered. One person told us, "The food is all right, the only problem is that you have to wait for a cup of tea. They don't have time to serve it with the meal."

The care records for one person who was at risk of malnutrition showed that the registered manager had taken the appropriate action to ensure that measures were in place to meet their nutritional needs and maintain their weight.

People gave us mixed feedback about how they were supported to access additional health care services when they needed them. Some people told us that they were regularly seen by a GP but the relative of one person said that the service had been, "Reluctant to get a doctor in," when the person was unwell. Another relative advised that it had taken, "Months," to arrange an optician's visit. However a GP who was visiting people who used the service felt that the staff responded promptly when people required additional support. They praised the care staff for dealing effectively with a wide range of complex care needs. Records showed that other health care professionals regularly visited the service.

We noted that staff did not always follow directions from visiting health care professionals. We saw that a person's medication had not been changed in response to instructions from a hospital physician. Another person was not receiving support to manage their sore skin in line with professional advice. Tissue viability nurses regularly visited the service and had provided specific instruction for staff to follow. At the inspection we noted these had not been followed and a nurse we spoke with could not explain why this was. However, the visiting nurse had also requested that the person's skin condition was monitored and records showed this had been done.

Requires improvement

Is the service caring?

Our findings

Most people we spoke with said that staff were pleasant and several relatives said they were very happy with how staff supported the people who used the service. Relatives we spoke with gave mixed views about the level of care people received. One relative gave us examples of how staff ensured that people's favourite foods and drinks were available another relative told us that they could not always speak to a person on their mobile phone because staff had not always supported the person to ensure that the phone battery was charged. This meant the person was unable to speak with the people who were important to them. A person who used the service told us how a member of staff would bring them in a daily newspaper which they enjoyed. However during our inspection the member of staff was on leave and no one else had taken responsibility to ensure the person still received a newspaper. The registered manager and a member of staff we spoke to were aware of this but had not arranged for the person to continue to receive a daily paper. The member of staff told us, "She only has to ask, I would have brought her one."

Relatives said that a lack of staff around the home meant that it was difficult for people to develop relationships with the staff who supported them. Staff told us they did not have time to sit with people in their rooms and develop social relationships. A relative we spoke with told us that when they had visited a person on the afternoon of their birthday, the person told them that no one had wished them happy birthday or had given them their post which included birthday cards when it had arrived earlier in the day. Several people who used the service said that staff attitude had changed. They said that staff had become "distant" from the people they were supporting.

Several relatives we spoke with described the service as, "Institutionalised," explaining that staff carried out their responsibilities to meet people's physical needs but did not always have regard to promoting people's general well-being and outlook. Comments included: "The care is fine, its more the mental side," "They've got their routines, staff don't get enough quality time with residents," "Staff just walk past everyone," "People just sit in front of the telly all day." One relative told us staff used to complete a daily diary detailing the person's feelings and how staff had interacted with them. This had helped the person who used the service and their relative to take an interest in the care they were receiving. They told us staff had stopped providing this detail and it was now, "A tick box of what the staff have to do, there's nothing personal. It's just, 'changed pad,' or 'got dressed.'" They said this meant that they had no way of knowing if anyone had been in to chat with their relative. This did not help to make people feel important or reassure relatives that staff were taking an interest in the people living in and using the service.

Some relatives gave us examples of how staff had supported people to pursue their interests and religious beliefs. These included supporting people to attend their chosen place of worship and make social visits into the community. We also saw that some people were encouraged to engage in group activities and we saw that there were regular visitors to the service.

People gave us mixed views about how they were supported to be involved in making decisions about the care they received. One person told us they were never approached for their opinion and some people said they were continually approached for their views of the care provided. The relatives of three people we spoke with told us they were involved with planning care when the person joined the service but this was not continued. A relative told us, "We had a get-together and agreed to give her what she wants. They were concerned." They then told us that they have not been involved in any further reviews and that the service now regarded the person as, "Part of the furniture."

Although many of the people who used the service were unable to say how they felt the registered manager had not ensured that communication aids were available to help people express their views about the care they received or be involved in how the service was developed.

We observed staff closing people's bedroom doors when providing personal care and staff we spoke with said it was important to support people's dignity and privacy. However we observed that some practices at the service did not always reflect this. It was standard practice to leave bedroom doors open so staff could monitor people being cared for in bed. People were not consulted on this practice and records did not indicate this was their preferred choice. This resulted in visitors to the service being able to see people in their nightwear and one person who could not get out of bed was visible to any visitors who were in the service's main reception.

Requires improvement

Is the service caring?

Staff failed to respect people's privacy and personal space. A relative we spoke with said staff needed to realise that the person's bedroom was, "Not just a room, it's her home." On two occasions when we asked to speak to staff in private they took us into the bedrooms of people who were currently in the lounge. They did not ask permission from the people whose rooms these were and we asked to leave their rooms. A member of staff could not understand our concerns and replied, "It's okay, they are in the lounge." We observed another member of staff take a break in a communal area. They took off their shoes and sat with their feet up on a sofa outside a person's bedroom and made personal phone calls. The member of staff was visible to the person in bed. This did not respect people's living space or privacy. The provider did not have their own polices and guidance for staff to support the privacy and dignity of the people who used the service. Although policies were available in reception, these were out of date and belonged to another provider. The registered manager told us they were producing their own policies.

Several relatives told us that staff did not always have time to ensure people were well groomed. They gave us several examples including finding people without their hair brushed, wearing dirty clothes or requiring personal care when they visited. We observed that several people who used the service appeared unkempt and were waiting to receive personal care and grooming. On both days of our inspection we often observed people being left unattended in the lounges and dining rooms without having their personal needs met. This included one person having to sit with her underwear exposed and another person attempting to eat a cooked meal with their hands because they were not being supported by staff. People were not being cared for in a dignified way.

We noted that people's bedrooms were untidy and several fittings such as drawer fronts were broken off. Some people's personal belongings and mementoes had not been unpacked since they moved into the service and remained in boxes. When some people received medical supplies these had not always been unpacked or put away promptly. These items remained in packing crates in people's bedrooms or outside their rooms. This did not promote a pleasant environment in which to live. In some instances visitors and residents were able to identify people's specific care needs from the supplies stored openly in people's bedrooms. This did not respect people's rights to confidentiality.

Requires improvement

Is the service responsive?

Our findings

We identified some issues which demonstrated that the service had failed to meet the differing needs of people using the service.

Most of the people we spoke with said they were happy at the service and felt staff responded appropriately to their care needs. However, several people told us and we saw that staff did not always respond promptly when people required or requested support. A relative we spoke to said that when they had informed a member of staff that a person was asking for assistance, they replied, "Oh that's so-and-so. It's her again. She's always calling." The relative said that staff did attend, "Eventually." Another relative told us that a person was not supported to engage in an activity they enjoyed. They said, "Staff put her to bed, take her glasses off her and they'll take the remote off her when she wants to sit in bed and watch TV."

A relative told us that the service was not responsive to a person's needs when their bed broke. Instead of moving a temporary bed into the person's room, the person was moved into another room with a temporary bed. This meant the person was not surrounded by their personal possessions and although there was a television in the new room, the relative told us the person did not like to use it, "As it wasn't theirs." The relative told us the person had been in the temporary bed for six weeks and said that, "She doesn't like it [the room]." The relative also told us that when the person broke their glasses, which they needed to enjoy television, staff did not notify them or attempt to locate a second pair which was in the person's handbag. The person was unable to watch televison until the relative attended and found the second pair of glasses themselves.

Several relatives told us that although people (and their relatives) had been initially involved in establishing care plans and expressing people's personal preferences, they were not involved in regular reviews. Therefore care records may not have contained up to date information for staff about how people wanted to be supported. The registered manager told us they had started a programme to review people's care records. Relatives told us that food and drinks were distributed at specific times and people were woken up and put to bed at set times which were not necessarily at the times people wanted. A member of staff we spoke with said they could not always get people up at the time they wanted because there was not always another member of staff available to assist them. We did however observe staff offer people drinks throughout the day.

These issues identified that the care and support provided to meet people's health care needs failed to consider their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a radio and television available in the main lounge and both of these were on constantly during our visit. We saw a member of staff in the lounge switch on some music in response to a person's request. However they did not check if this was what the other people in the lounge wanted to listen to and the television was also on at the same time. This made it difficult for people to follow their chosen television programme. On one occasion a member of staff also started to vacuum the floor while people were watching television or listening to the radio. This distracted from people's chosen activities. A person who used the service told us they often complained about the noise in the lounge and were always advised by staff to go to their room. The staff had not attempted to find an alternative solution such as changing the domestic routines or helping to find or identify a designated quiet area. The person told us they had given up raising this issue.

Care records contained details of people's interests and some people gave us examples of how the service had responded to their expressed preferences for activities. These included visits to the cinema and theatre. One relative was very pleased with how a person was supported to visit the theatre and we saw that people were supported to follow their religious preferences, however we found that this support was not experienced by all people who used the service.

We often saw people's requests for support go unanswered by staff. We saw several people trying to get the attention of staff as they walked past them but to no avail. One person kept saying they wanted to go to the toilet. Two people we spoke with told us they often gave up trying to get attention from staff, feeling it was a fruitless task. Throughout our visit people regularly approached members of the inspection team for assistance because staff were unavailable to support people promptly with their personal care.

Requires improvement

Is the service responsive?

There were two activities coordinators at the service and we saw a daily activities board. This showed that only religious activities were available over the weekend and several personal care tasks such as hairdressing and nail care were deemed to be activities. These activities would not be appropriate for everyone who used the service. We spoke with one activities coordinator who spoke fondly of the people they supported but it was apparent that activities offered were group based. There was no formal programme to ensure people who remained in their bedrooms would be supported to take part in activities or pursue their individual interests. We did see however that some people who enjoyed reading were supported by a visiting library service. The activities coordinator was unable to tell us what activities would be provided when they were not on duty at the home as these would be decided on by the other activities coordinator. The two coordinators did not liaise or plan what meaningful activities would be provided to occupy or entertain people.

We saw that activities were not always organised to reflect people's individual preferences or needs. During our inspection we saw people were supported to decorate biscuits but there was no alternative activity offered to people who chose not to. Although most people appeared to be enjoying this activity was evident that it was not appropriate for some people who were encouraged to take part because it was not suited to their limited motor skills. One person who decorated a biscuit was unable to eat it because of their specific health condition. There were no alternative or more suitable activities offered.

People we spoke with felt that concerns were not responded to promptly. One relative told us they approached the registered manager for a meeting a week ago to discuss some concerns but had not received a response. Another relative said they were, "Asking staff all the time," for some specific information but staff had not supplied this, despite promising to do so. The relative said this had been an on-going concern for several months. After our inspection we saw evidence that several members of staff had raised concerns about the quality of the service with the registered manager and provider several weeks before our visit. This was not disclosed to us by the registered manager when we visited and we saw no evidence that they or the provider had taken action to respond to the concerns raised. Staff we spoke to after our visit told us these concerns remained unresolved and as a result we raised these concerns with the local safeguarding authority.

The registered manager had a complaints process and we saw this displayed around the home. The registered manager maintained a complaints log, but this was not always completed sufficiently to review incidences in order to identify any adverse trends and the actions required to reduce the risk of them happening again. The provider did not have a robust system to review and learn from complaints and concerns.

Requires improvement

Is the service well-led?

Our findings

The provider's processes for monitoring and improving the quality of the service in line with regulations were not robust.

The provider had failed to identify that a new employee had not provided evidence of their care qualifications or appropriate references and had started working at the service without suitable police checks being completed.

Although the registered manager had informed the Care Quality Commission of some specific events the provider is required, by law, to notify us about, they did not notify us of all the events they were required to, such as the risk of harm from medication errors and allegations of financial abuse. The registered manager and provider did not notify the local safeguarding authority when they received information that people who used the service were at risk of harm. This demonstrated that the nominated individual for the service and registered manager were unclear of their responsibilities to other agencies.

The systems in place to monitor the management of medication were not consistently effective and had failed to identify issues noted at the inspection.

The provider did not promote a clear organisational and management structure. The registered manager told us they often used staff from what they believed was another home operated by a director of the provider under a different company. The registered manager told us that had determined that it was unnecessary for the service to conduct the appropriate checks to ensure that these members of staff were suitable to support people because they believed these would already have been undertaken at the provider's other location. They had not sought assurance or confirmation of the staff suitability and skill levels.

The registered manager did not promote a positive culture which was person centred. Although the registered manager had made several attempts to hold residents and relatives meetings, these were poorly attended. The registered manager had not found an effective way of supporting people to be involved in developing the service. Several relatives we spoke with said that people were supported according to the needs of staff instead of their own personal needs. They summarised this by calling the service, "Institutionalised." The registered manager did not keep under review the day to day culture in the service in place or identify when there were insufficient staff or deployment to ensure that they met people's needs and wishes.

There was information about the provider's vision for the service around the home to provide person centred care which included treating people with respect. We noted that staff did not act in accordance with this vision. Staff told us that they did not have annual appraisals or regular supervisions to identify how they could best improve the care people received. This did not enable the registered manager to promote their vision for the service to staff or provide staff with the necessary support and guidance to meet peoples' needs. The registered manager told us that they were working with staff to introduce several changes to how the service operated and this had caused resentment with some members of staff

The failure to assess, monitor and improve the service and mitigate any known risks was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had produced a plan of how they would respond to concerns raised by commissioners of a local clinical commissioning group. Although actions had been taken our observations during the visit showed they had not always been effective. The registered manager told us that they were expecting our inspection report to provide them and staff with the actions they would need to undertake in order to improve the service.

We spoke to the provider's audit controller who was visiting as part of their induction to the service. They were unable to identify what aspects of the service they would be monitoring or how they would do this. They explained they were on an induction course and were unaware of the provider's requirements or expectations of their role. The formal processes the provider undertook to monitor the quality of the service were unclear and not known to staff.

We saw that the service used stationary, uniforms and policies from a previous provider at the premises and these had not been updated to reflect the change in ownership in August 2014. The provider displayed a Care Quality Commission inspection report and food hygiene certificate in their reception which related to the service when it was operated by another provider. The registered manager had also displayed a sign directing visitors to the report

Requires improvement

Is the service well-led?

claiming it as their own. The sign stated the provider's service had been rated as, "Good," by the Commission. The registered manager said they did not realise the report would no longer be valid when a new provider took over the service. This presented misleading information to visitors and after discussion the registered manager removed the sign.

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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 legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care service users received was not designed with a view to achieving service user's preferences and ensuring their needs were met. Regulation 9 (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure they had robust systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a). The provider did not ensure they had robust systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (2) (b). The provider did not ensure they had robust systems to maintain securely an accurate, complete and contemporaneous record in respect of each service users, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c).

This section is primarily information for the provider

Action we have told the provider to take

The provider did not seek out and act on feedback from relevant persons for the purpose of continually evaluating and improving the service. Regulation 17(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014: Staffing. There were not sufficient numbers of suitable qualified, competent, skilled and experienced person's deployed in order to meet the requirements of service users. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that Persons employed for the purposes of carrying on a regulated activity were of fit character or have the qualifications, competence, skills and experience necessary for the work to be performed by them. Regulation 19 (2)(a)