Bupa Care Homes (CFHCare) Limited

Gallions View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 28 and 29 July and 2 August 2016 and was unannounced. At the last comprehensive inspection of this service on 25 and 26 November 2015 we found breaches in legal requirements in relation to safe care and treatment and monitoring the quality and safety of the service. We took enforcement action and imposed a condition on the provider's registration so that we could monitor the action being taken by the provider to address the concerns we found. We required the provider to submit information to us on a monthly basis and this came in to effect in February 2016.

We received further concerns about the service and carried out a focused inspection on 7 March 2016. At this focused inspection we found continued breaches of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in relation to safe care and treatment and monitoring the quality and safety of the service. We placed a condition on the service's registration that no new admissions could be made to the home.

Gallion's View Nursing Home provides personal care and nursing care to older people and those living with dementia. The service can accommodate up to 120 people in four separate buildings. At the time of this inspection 82 people were using the service. The day before our inspection one of the units was temporarily closed and people who used the service were moved to two out of the three remaining units.

The service had a registered manager who has been in post since 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, at the time of our inspection the registered manager had been on extended leave since June 2016. The deputy manager was managing the service as acting manager and was being supported by the provider's recovery team who oversee and support improvement

At this inspection we found continued breaches of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

People's safety had been compromised in that medicines were not always managed safely. Risks to people had been identified but care plans did not always record guidance in order for staff to enable staff to manage these risks safely accident and incident logs were not always completed. Audits had either not been carried out or were not always effective in identifying shortfalls in the safety or quality of the service

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

Mental capacity assessments and 'best interests' meetings were not always carried out in with the MCA when there were concerns regarding a person's ability to make a decision. Care plan audits did not always

identify the risks recorded by healthcare professionals and people were not always referred back to healthcare professionals for follow ups or reviews. Care plans did not always record guidance for staff on how to support and meet people's needs. Complaints were not logged, investigated, monitored or maintained in line with the service's complaints policy. The number of staff deployed across the three units, were not always enough to meet the needs of people who used the service. Staff did not feel consulted or involved in the running of the service and told us communication with management was poor. You can see the action we have asked the provider to take in respect of these breaches at the back of the full version of the report.

We saw at times staff interaction with people was limited unless they were task orientated. We found activities offered at the home required improvement to meet people's needs for stimulation and social interaction.

Safeguarding adult's procedures were robust and staff understood how to safeguard the people they supported. There was a whistle-blowing procedure available and staff said they would use it if they needed to. Appropriate recruitment checks took place before staff started work.

Staff received supervision, appraisals and training appropriate to their needs and the needs of people they supported to enable them to carry out their roles effectively. There were processes in place to ensure staff new to the service were inducted into the service appropriately.

Staff respected people's privacy and dignity. Staff knew people well and remembered things that were important to them so that they received person-centred care. People's nutritional needs and preferences were met.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to consider the process of preventing the provider from operating this service. This may lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement and there is still a rating of inadequate for any key question or overall, we may take action to prevent the provider from operating this service. This may lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

The systems for the management of medicines were not always safe.

Risks to people had been identified but care plans did not always record guidance in order for staff to enable staff to manage these risks safely.

There were not enough staff on duty to meet people's needs.

There were appropriate safeguarding procedures in place and staff had a clear understanding of these procedures.

Appropriate recruitment checks took place before staff started work.

Is the service effective?

Requires Improvement

The service was not effective.

Healthcare professionals had not always been involved in follow up reviews of people's care and treatment.

Staff had received training on the requirements of the Mental Capacity Act 2005 code of practice and Deprivation of Liberty Safeguards but people's capacity to consent to some specific decisions was not always assessed.

Staff training was up to date. Staff had received appropriate support through formal supervisions and appraisals.

People were supported to have enough to eat and drink.

Is the service caring?

Good

The service was caring

People were treated with dignity and privacy was protected.

Staff encouraged people to be as independent as possible.

People were involved in making decisions about their care. and treatment. However at times staff interactions with people were limited unless they were task orientated .

Is the service responsive?

Requires Improvement

The service was not responsive

Complaints were not logged, investigated, monitored and maintained in line with service's complaints policy.

Care plans were not always updated to include up to date guidance to enable staff to meet people's needs.

There were insufficient meaningful or regular activities on offer to meet people's need for stimulation.

Is the service well-led?

Inadequate

The service was not well-led

Audits had either not been carried out or were not always effective in identifying shortfalls in the safety or quality of the service.

Staff did not feel listened to and staff morale was low throughout the service.

People's views had been sought about the service to help drive improvements.

Gallions View Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 28 and 29 July and 2 August 2016 and was undertaken by two adult social care inspectors, one pharmacy inspector, one specialist advisor and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service including information from notifications they had sent us. We also asked the local authority commissioning the service and the safeguarding team for their views of the service.

We spoke with 13 people who used the service, four relatives, 13 members of staff, the acting manager, the clinical lead and two members of the provider's recovery team who support and oversee improvements. We reviewed records, including the care records of nine people who used the service and 14 staff members' recruitment files and training records. We also looked at records related to the management of the service such quality audits, accident and incident records and policies and procedures.

Inadequate

Is the service safe?

Our findings

Two relatives we spoke to said they felt their relatives were safe. One healthcare professional we spoke to told us, "People are safe." However our findings at this inspection identified continued concerns about people's safety.

At our previous comprehensive inspection of the service on 25 and 26 November 2015 we had found risks to people had not always been identified or properly assessed, and action had not always been taken to manage risks safely. Staff had not always protected people against the risk of receiving inappropriate or unsafe care. For example staff had not used malnutrition risk assessment tool guidance appropriately. People were therefore not always referred to healthcare professionals when needed. Wound care charts for people were not always fully completed to track and monitor any risk of deterioration and the progression in terms of healing. Staff had had not always followed guidance given by the Tissue Viability Nurse (TVN is a nurse who specialises in skin integrity) in relation to dressings and the care of people's wounds. We also found that medicines were not stored and refrigerated properly. We had rated the service Inadequate in 'Safe'.

At our focussed inspection of 7 March 2016 we again found that risks to people had not always been identified or properly assessed and action had not always been taken to manage risks safely. For example, following incidents that occurred, risk assessments were not carried out to assess the level and extent of risk and what could be done to reduce risk. People's experience of pain was not assessed to understand how to alleviate it. Following incidents care plans were not updated to provide guidance for staff on how to manage risks. The service remained rated as 'Inadequate.'

At this inspection of 28 and 29 July and 2 August 2016 we found improvements had been made in the completion of malnutrition risk assessment tools and weight loss had been identified and acted on in most cases. However, we found that although risks to people had been identified, care plans were not always updated to record guidance in order for staff to enable staff to manage these risks safely. For example we saw that where people were under the care of the Tissue Viability Nurse (TVN) they were not always referred back to them when there was deterioration in their condition and the GP was not always consulted for guidance. We raised this with the acting manager who told us that the home felt that they were managing the person's pressure ulcer and so did not feel that they needed the TVN to be further involved. This was despite the fact the TVN had advised for the wound to be reviewed a TVN within two weeks.

Risks to people had been identified but care plans did not always record guidance from healthcare professionals in order for staff to enable staff to manage these risks safely. For example, we saw one person had been left unsupervised to have breakfast in bed whilst they were lying down in bed. We looked at this person's care file and saw that there were specific instructions from a Speech and Language Therapist (SALT) on how the person should be supported whilst eating, i.e. they should be remain upright, take a drink and breathe before the next mouthful. However we saw this information had not been added to the care plan, therefore staff, were not following the SALT's advice when leaving this person to eat unsupervised. This left the person at risk of unsafe care being delivered. We also saw that staff were not aware of the needs of

people who had moved from the unit that had closed. For example a member of staff had to ask a unit manager if one person took sugar in their tea. The unit manager advised 'No' as the person was diabetic.

Where people demonstrated behaviour that required a response and placed them and others at risk of possible accidental injury, we found staff had no guidance from care plans on how to respond safely and effectively. Staff were observed to be unsure how to respond. There was no risk assessment in place to assess and identify the possible risks and what action could be taken to mitigate them. Behavioural charts were in place for staff to record incidents, but we found there were no details or analysis of the person's behaviour to help support staff in meeting this person's needs or to identify any patterns. For example what might trigger some behaviour or if the person's behaviour was different in the morning to the afternoon.

We saw accidents forms were not always completed following an accident. For example one person suffered a fall on 5 July 2016; the same person suffered another fall on 28 July 2016.No accident forms had been completed for these falls. We asked the acting manager about this and they confirmed they could not locate them. This meant that accidents were not being managed in a way where risks were identified and people were protected from the likelihood of recurrences.

These are a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Following the inspection, the provider sent us documentation to show that they had taken action to obtain specialist advice from the TVN regarding wound review.

There were procedures in place to deal with foreseeable emergencies. Staff told us they knew what to do in response to a medical emergency or fire, and they had received first aid and fire training. Records confirmed this. The fire risk assessment for the home was up to date and personal emergency evacuation plans were in place for people using the service to ensure their safety in the event of a fire. Water, gas and fire equipment were maintained under a contract and records of maintenance were up to date.

We found that medicines were not managed safely. We saw that on one unit, fridge temperature records were not always complete. We found that temperatures were not recorded for two days in June 2016 and for three days in July 2016. Medicines which are stored at temperatures outside of the manufacturer's recommended parameters can spoil and become ineffective. The service could therefore not assure itself of the efficacy of medicines people were receiving.

We found discontinued medicines were stored in the medicines trolley; this meant there was a risk that people may be given medicines that were no longer effective. Medicines administration records were not maintained consistently. For example, we looked at Medicine Administration Records (MAR) for six people for July 2016 and found that the MAR for five people had one occasion each, where the MAR had not been signed to confirm people had received their medicines as prescribed. The MAR for the sixth person had six occasions where it had not been signed. When we reconciled medicines against the MAR we could not find the medicines in the monitored dosage system, however, we could also not confirm that medicines had been administered to people. We looked at MAR for a further six people for July 2016 and found that there were eight occasions where the MAR had not been signed. However, we could not reconcile stocks because we could not find the medicines or the balances did not tally with the records. We also saw that one person had been prescribed a particular medicine three times a day with 21 tablets supplied. We saw nine doses had been recorded as administered which included four doses on one day instead of three. We therefore expected to find 12 capsules remaining but counted only 11. This meant that medicines and administration records were not being managed safely and effectively.

These issues are a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

We raised this with the acting manager who told us that an immediate review of the medicines trolley would be undertaken to ensure there were no discontinued medicines stored and that a medicine audit had been undertaken by the clinical lead during the course of our inspection but not completed so we were unable to review the findings.

One person we spoke to told us "I keep calling for help, but nobody comes". A relative we spoke with told us "They don't have enough staff, I came in yesterday (27th July 2016) at 12.15pm and my husband was wet, his sheet was wet and he hadn't been washed. [Staff] said they were busy." Another relative told us "I don't even know if they do the checks every 4 hours. But I can be here at 12pm and no one comes by the time I leave at 6pm". A relative told us, a care worker started to leave the lounge and then realised there were no other staff present and said "Oh, I need to hang around, there's no-one else here." A third relative said "I could be here for 20 minutes and not see a member of staff." A fourth relative told us "I don't like it when residents say they want the toilet and its lunch, but this is a no-go. [Staff] say "You'll have to wait, we're doing lunch, there are just not enough staff." One Staff Member we spoke to told us "There are not enough staff and this has been going on for a long time".

We observed that there were not enough staff on duty to adequately meet peoples' needs. On the first day of the inspection we saw on one unit that people were still receiving their breakfast at 10.30am. We asked staff about this, they told us that usually most people on the unit had their breakfast before 9.30am, We saw that people who had transferred onto the unit were due to attend a welcome party in the afternoon, however we saw some of them were still in bed early afternoon and waiting to get up. Staff told us due to the people who had been transferred onto the unit the day before, staff numbers had not been increased to ensure peoples' needs were met in a timely manner.

On the first day of the inspection staff told us they had to leave medicine rounds or dressings to go and support and advise care workers who were not familiar with the new people to the unit's needs.

Staff told us they had not been told of the actual date of when people were going to be transferred from the unit that had closed and that no extra staff had been deployed onto the two units that people had been moved onto help reduce any concerns people might have with the changes and to allow a smooth transition. Staff told us they were also worried about staffing levels overnight. This was mainly due to the high dependency needs people on all units and that more often than not they needed two people to assist them. They expressed concerns that two care staff and one nurse were not enough to meets people's needs overnight.

We saw that that people who needed close monitoring because of possible risks were left unsupervised in the lounge together with other people who used the service for up to 10 minutes at a time throughout the inspection.

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

We brought these matters to the attention of the acting manager and the recovery team, who support and oversee improvements, and saw that on the second day of the inspection we saw that extra staff had been deployed to the unit that acquired the most people from the unit that closed. We saw people who wanted to get up were sitting in the lounge and had their breakfast at their usual times. That recovery team, who

support and oversee improvement at the service, told us that henceforth this unit would permanently have two RGNs allocated. We found that this was the case when we visited the unit on 2 August 2016, the third day of our inspection. The recovery team also told us that following the inspection they would be re-evaluate staffing levels taking into account the dependency levels in the three remaining units. However we were unable to monitor this at the time of the inspection.

Staff were aware of safeguarding policies and procedures and knew what action to take to protect people should they have any concerns. Staff we spoke with demonstrated an understanding of the type of abuse that could occur. They told us the signs they would look for, what they would do if they thought someone was at risk of abuse and who they would report any safeguarding concerns to. Staff told us they were aware of the organisation's whistleblowing policy and they would use it if they needed to. The provider had notified us of some safeguarding investigations which were ongoing at the time of the inspection. CQC will monitor the outcome of these investigations.

There were safe recruitment practices in place and appropriate recruitment checks were conducted before staff started work at the service. Staff files contained a completed application form which included details of staff's employment history and qualifications. Each file also contained evidence that confirmed references had been sought, proof of identity reviewed and criminal record checks undertaken for each staff member.

Requires Improvement

Is the service effective?

Our findings

One relative we spoke with told us "In general staff are very good." Another relative told us "There are some good carers." However we found that some improvement was required in line with the requirements of the Mental Capacity Act (2005).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked to see whether people's rights had been protected by assessments under the MCA. We found that people's capacity and rights to make decisions about their care and treatment were not always assessed in line with Mental Capacity Act 2005 (MCA 2005). We found that decision specific capacity assessments were not always being completed. For example, one person had refused personal care for a long period of time and declined to be weighed for several months so their weight could not be monitored. We found that staff had not taken considered the need for a mental capacity assessment in relation to these decisions. There were no best interests meetings which involved relatives and healthcare professionals in relation to the care provided.

We found another person had recently been referred to a speech and language therapist (SALT) Both the family and the SALT agreed on soft mashable diet. However there was no best interests discussions recorded in the person's care plan. The mental capacity assessments on file for both these people did not record the specific decision that was being assessed. This was not in line with current guidance and the law.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider followed the requirements of DoLS and had submitted applications to appropriate supervisory Bodies as required to request the authority to legally deprive people of their liberty when it was in their best interests.
We saw that applications under DoLS had been authorised and that the provider was complying with the conditions applied under each authorisation.
Staff were aware of the importance of gaining consent from people when offering them support. One staff member said, "I always ask people for their consent before I offer support and tell them what I am doing."

Staff training records confirmed that new staff had completed an induction when they started work which included shadowing other staff. Staff told us and records confirmed that they had undertaken with their mandatory training and refresher courses which included safeguarding, mental capacity, manual handling and medicines training. One staff member told us, "All my training is up to date and I asked for dementia training which I have been on." Another staff member told us "I have done all my training, I do it every year."

Staff were supported through regular supervision and annual appraisals in line with the provider's policy. Staff supervision records confirmed they discussed a range of topics including issues relating to the people they supported and progress in their role. Annual appraisals had been conducted for all staff that had completed a full year in service. The frequency of supervision meant that if there were any shortfalls in knowledge or training this could be picked up promptly and addressed so that people continued to receive appropriate standards of care. One staff member we spoke with told us, "I have regular supervisions where I can get feedback."

At our last comprehensive inspection on 25 and 26 November we had found some improvement was needed as staff had not always followed the service's procedure and guidance on monitoring people's nutrition and hydration to ensure they met their needs; as food and fluid intake charts were not consistently completed. At this inspection we found that Malnutrition Universal Screen Tool (MUST) assessments and food and fluid charts were being completed to identify people who were at risk of malnutrition and dehydration. People told us they had enough to eat and drink and that they had a choice of what to eat and where to have their meals. One person told us "The tea is excellent" and "the food is good. Kitchen staff were aware of people's dietary needs and allergies as well as people's nutritional and cultural needs. Some people were on fortified diets to help maintain their weight. We observed that some people chose to eat in their rooms. We heard mixed views from relatives about the food ranging from "The food is home-made, like the pastry and so on, you can tell" and "They dish it up nicely, two choices per meal".

We observed how people were being supported and cared for at lunchtime. Some people required support with eating and some ate independently. People had adapted cutlery or crockery where needed to help them maintain independence. We saw food and fluid intake charts were completed to monitor people's intake where needed.

Good

Is the service caring?

Our findings

People told us that the service was caring. One person told us "The staff are very kind to me, never seen anyone nasty," and "there are some good carers."

We observed that at times staff interactions with people were task orientated and we have discussed this in the 'Safe' section of this report. Although staff were short of time we saw individual staff maintained a caring approach. We saw that when staff approached people who used the service they got down to their level to speak to them. We saw one member of staff gently stroke the cheek of a person who used the service. We saw the staff were kind and were largely cheerful. Individual staff were caring overall in their approach to people.

We saw people were involved in planning their care and support. The service had involved people and their relatives, where appropriate, to develop their care plans and make decisions in relation to their care. Care plans contained people's life history to inform staff and preferences about their care. For example, what their former occupation was and what they preferred to be called. Staff were able to describe the individual needs of people who used the service. For example, the time people liked to go to bed and wake up, and the types of food they liked and disliked and what interests they had.

Staff knew how to ensure that people received care and support in a dignified way and which maintained their privacy. For example, we saw staff knocked on people's bedroom doors before entering and kept bedroom doors closed when they were supporting people. A staff member we spoke with told us "I close doors and tell people what I am doing." Staff told us they promoted people's independence by encouraging them to carry out aspects of their personal care such as washing and dressing.

Staff showed an understanding of equality and diversity. Care records included details about people's ethnicity, preferred faith, culture and spiritual needs, and staff confirmed people were supported in these areas where appropriate. For example, regular church services were held at the home for people who wish to attend. People's cultural dietary needs were taken into consideration and planned for. For example, the chef told us that some people liked Caribbean and Nepalese curries and that they regularly cooked them. The chef showed us a Caribbean cookbook that was frequently used to make different dishes.

People received support to make day to day decisions about their life. For example, a member of staff said to a person, "Would you like to watch a film?" The person had declined the offer and the member of staff had respected their decision.

We saw people's bedrooms were personalised with their own belongings and furniture. People's rooms had memory boxes outside their rooms to help them orientate themselves as much as possible. We saw people were well presented and looked clean and comfortable. People were supported to see relatives and friends and they could have visitors at any time. On the day of our inspection we observed staff warmly welcoming relatives when they visited.

People were given information about the service. We saw people were provided with appropriate information about the service in the form of a service user guide which included the complaints policy. This guide outlined the standard of care to expect and the services and facilities provided at the service.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke to told us "I asked [Staff] to clean the ceiling lights, but no one has done them".

The service had a complaints handling process, but improvements were needed as it was not effective. We saw that the service maintained a complaints folder but there were no complaints logged since January 2016.However, it was brought to our attention that a relative of a person who used the service had raised a serious complaint the week before the inspection. There were no records to show that this complaint had been logged or investigated in line with the service's complaints policy. One relative we spoke to told us they had made several complaints but had received very few responses to the complaints they had made.

These issues are a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

We brought this to the attention of the acting manager who told us that all complaints in the future would be investigated in line with the service's complaints procedure. However, we were unable to monitor this at the time of our inspection. We saw the complaints procedure was available to people in each of the units should they wish to make a complaint.

Following the inspection the provider sent us records to show that they had logged complaints since January 2016 on their internal central system, although this did not include the serious complaint raised by a relative the week before our inspection on 28 July 2016. We will monitor this when we next inspect the service.

There was a risk that people would not have received care and support appropriate to their current level of needs. At our previous inspection on 25 and 26 November 2015 we found six care plans that did not have up to date reviews on people's skin care or Malnutrition Universal Screening Tool (MUST) assessments. At this inspection we found MUST assessments were regularly reviewed. Although care plans had been reviewed, three care plans we looked at had not been updated to reflect a change in people needs and the support they required. The care plans had not been updated to provide up to date guidance for staff on how to support people. For example, one person was being nursed on a pressure mattress and the care plan did not clearly record the frequency of repositioning of the person whilst they were in bed. This meant people were not having their care needs met and improvement was required. We raised the issue of the frequency of repositioning instructions not being recorded clearly for staff. The clinical lead told us that they would ensure that the person's care plan read the person must be turned on a four hourly basis.
We saw care files addressed a range of needs such as communication, personal hygiene, nutrition, physical needs. Each person also had a personal profile in place, which provided important information about the person such as date of birth, gender, ethnicity, religion, next of kin and family details, and contact information for healthcare specialists.

Activities to engage and stimulate people required improvement. The service had two full-time activities co-ordinators who worked during the week. We saw there was an activities list on each unit offering a range of

activities which included bingo, arts and crafts, manicures and arm chair exercises. Although the two activities co-ordinators were present throughout our inspection we did not see any activities being undertaken, except for a welcome party on the two units people had moved into. However, these were not well attended as staff had not managed to get everyone up from bed and ready to attend. We saw one of the co-ordinators was situated in one unit only. This co-ordinator was walking around and briefly asking people how they were but people were not engaged in any meaningful activities or conversations. We saw the other co-ordinator moving between the two other units, but noted they were usually serving drinks or engaging people in conversation. We did not see this co-ordinator undertaking any meaningful activities either. We saw on one unit that the same film was played for people two days in a row.

We spoke to one of the co-ordinators who told us that the activities programme had "got lost" in recent months, however, the acting manager and the recovery team were in the process of overhauling it and they hoped to start providing meaningful and personalised activities for everyone who used the service. However, we were unable to monitor this at the time of our inspection.

Inadequate

Is the service well-led?

Our findings

At our previous inspections of 25 and 26 November 2015 and 7 March 2016, we found the provider had not used audit findings to effectively manage identified risks to people and improve the quality of the service. We found that risks to people had not always been identified or properly assessed, and action had not always been taken to manage risks safely. After our November 2015 inspection we imposed a condition on the provider's registration to provide monthly audits of risk assessments and records of care delivery for all service users to be submitted. However despite this, at our inspection on 7 March 2016 inspection and this inspection of 28 and 29 July 2016 we found some concerns that the provider had not identified or acted on. The service was not well-led.

We found that prior to this inspection the registered manager (who at the time of our inspection was on leave) had monitored the quality of care planning and risk management. However, they had failed to pick up the concerns highlighted in this report and effective action had not been taken to manage and oversee clinical risks. For example, the registered manager had not followed up on audits on risks to people's health by ensuring that speech and language therapists guidance had been followed up and that care plans had been updated to reflect guidance. The absence of accident and incident reporting had not been identified or addressed. Audits of care plans had not always identified the issues we found at this inspection.

There were no systems in place for the effective handover of information from the registered manager to the acting manager. We found that that weekly and monthly medicine audits and monthly 'home manager metric audits' which were audits that reviewed areas such as the wound management, care plans, complaints infection control and the environment were not available. The acting manager and the recovery team told us that these audits could not be located in the registered manager's absence. This meant that issues we found in this inspection were not identified and appropriate action was not taken to minimise the risks and improve the quality of the service.

We saw the registered manager undertook an audit of the care plans on 31 May 2016 and that one person's care plan had instructions from speech and language therapist advising that full supervision should be given when the person was eating or drinking due to risks from feeding. This guidance was not recorded in the person's eating and drinking care plan. Although the registered manager had identified this issue, the care plans had not been updated to include this guidance. Systems in place to check on the quality and safety of care and mitigate risks were not adequate.

Although we saw that people using the service and their families had been informed before-hand of the planned unit closure and were also advised of a target date when this would be done, we found an absence of effective planning and leadership in relation to the unit that had been temporarily closed the day before the inspection regarding the preparation of staff. On the first day of the inspection we found that while staff told us they had received a verbal handover they had no written guidance to help them understand the needs of people newly admitted to the unit, who staff were not familiar with. There was no guidance available about people's dietary needs or their routines or preferences. For example, there were no risk assessments in place or any other records to show that staff had been given guidelines in order to reduce

disruption and distress to people with behaviours that required a response during and after the move. The service used records of care needs called 'at a glance' to identify care and support needs quickly. There were no 'at a glance information 'records on one unit for staff to familiarise themselves instantly with people's health and support needs for those service users who were unknown to them. There was no up to date list of people's dietary requirements for one unit on the 28 July 2016 until this was reported to staff by the inspection team.

We also saw on the first day of our inspection there were not enough staff on the unit to meet people's needs. Nine people had been transferred onto the unit but the number of staff had not been increased to effectively manage people's needs. Therefore the lack of effective planning meant people could have been put at risk of unsafe care and treatment.

Systems in place to improve the safety and quality of care for people were not effective. Regular clinical review meetings took place, however, these meetings failed to identify and monitor issues with people's skin integrity and weight loss. For example, one person's pressure sore had deteriorated but no action was taken to involve healthcare professionals. People's weights were monitored but where people had refused to be weighed there was no evidence of monitoring and review at clinical review meetings.

These issues are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

We brought the issues we identified to the attention of the acting manager and recovery team who took steps to start to address our concerns on the day of inspection. The acting manager and recovery team explained that the issues were as a result of the temporary closure of one unit and did not reflect the normal running of the service. We will check on this at our next inspection.

Regular staff meetings were held on each unit. Minutes of these meetings confirmed discussions took place around training, safeguarding and food and fluid charts. However staff we spoke to told us that the service did not have an open and transparent culture. Although the closure of one of the unit's was planned and families were consulted, staff we spoke to told us that the management had not told them the actual date of the closure and when people would be transferred to other units. We discussed this with the recovery team who told us that they had not told staff of the actual date of the closure in case it was interpreted that the service as a whole was going to close when this was not the case. However the lack of open communication had led to staff being unprepared for the change.

We received mixed reviews about the leadership of the service. One staff member told us "When the registered manager was here there were staff shortages but it was never as bad as it is now as the manager pushed for extra staff." Another staff member told us "Management does not communicate with staff and staff are leaving due to low morale." A third staff member told us "The acting manager and the clinical lead are brilliant, I feel more supported now with them and the recovery team being here." The majority of staff we spoke to told us that presently they were not happy working within the service. We raised this with the acting manager and the recovery team who told us that they would imminently be holding staff meetings at each of the units to allow staff to feedback their concerns, listen and to act on improving the service once they had collated all the feedback. We saw that a recent staff survey 2016 was carried out and found comments included "…We feel we don't get appreciation for the good we do. We only get criticised and are constantly short staffed." and "Short staffed most of the time". We were told that the survey had been analysed and head office were preparing an action plan but this was not in place at the time for the inspection.

We saw regular resident meetings were held to provide people with an opportunity to air their views about the service. Minutes of these meetings showed they items discussed included, food, activities, evening entertainment and re-iterating that the registered manager operated an open-door policy. We saw there was an action plan in place to introduce photos of staff on each of the units and murals on walls for the dementia unit to aid recognition.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not always act in accordance with the Mental Capacity Act 2005. Regulation11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not logged, investigated, monitored and maintained in line with service's complaints policy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service was not adequately staffed in order to meet people's needs. Regulation Regulation 18(1).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected by assessments of the risks to their health, safety and well-being. regulation 12 (1) (2) (a) (b). People who use services were not protected from the unsafe management of medicines. Regulation 12 (1) (2) (g).

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Audits had either not been carried out or were not always effective in identifying shortfalls in the safety or quality of the service. Risks to health, safety and welfare of people were not always monitored and mitigated. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

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